BULGARIA HEALTH REFORM PROJECT

Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810

JANUARY 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

Prepared by:

BearingPoint, Inc.
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USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 7
January, 2004

Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
Contract Number:	PCE-I-00-00-00014-00
Task Order:	810
Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

General

- Mr. I.Shehata met with Dr.Salchev, deputy Minister of Health, to discuss the future activities in the work of BHRP and MoH for 2004. As a result a Protocol with Priorities for 2004 was signed between Dr.Salchev and Mr. Shehata. It was agreed that the priorities for 2004 would be the hospital reform, the implementation of DGRs, the institutionalization of National Health Accounts, and the development of benefit package and co-payment schemes. (see Annex 1)
- The BHRP team was guest in the Parliamentary Health Commission during the discussions on the National Framework Contract 2004. The National Health Insurance Fund, the professional organizations and the MoH presented their positions regarding the inpatient and outpatient care.
- The director of the NHIF Dr. Dimitar Petrov was dismissed on the 20th of January and acting deputy for director was named Dr. Ivan Bukarev, director of the RHIF–Sofia.

Inpatient Care Financing

- From January 11th through January 16th 2004 BHRP attended a training program on DRGs funded by USAID and developed by Georgetown University/ INDEX Foundation in Velingrad. The program was focused on the western European experience. The training was for experts from the MOH, NHIF and the Physician union and it held by trainers from Poland, Finland and Switzerland;
- BHRP continued their assistance to the counterparts. COP met with Dr. Drenski to discuss the technical issues on the implementation of the case – based payment and Mrs. Jugna Shah's visit.
- Jugna Shah, a DRG advisor for BHRP arrived in Bulgaria for 2 weeks on 26 January to provide technical assistance to the NHIF and the MOH with their plan to move towards a case-based payment scheme based on DRGs. During her 1st week stay Ms. Shah met with the deputy minister of health – Dr. Salchev to discuss steps needed to implement a case based payment system based on DRGs. Ms. Shah also answered some of the concerns that were raised by Dr. Salchev regarding the readiness of Bulgaria to implement the system. She also met Dr. Sterev to discuss the implementation steps that are required so to move forward. Ms Shah also with Dr. Drenski to discuss the progress made with the data receiving from the pilot project hospitals.

During all her meetings she delivered the message that certain decisions should be taken. That requires meeting not just of the technical group, but also and will from the decision-makers. She grounded that a date should be set as soon as possible for the decision makers meeting. The date was set for Feb. 5

Mrs. Shah started meetings on a daily base with Dr. Drenski and to put together the materials that should be presented to the decision-makers.

National Health Accounts

- Mr. I. Shehata met with Dr.Shterev, Chairman of the Parliamentary Health Commission, and Dr. Salchev, deputy Minister of Health, to discuss the beginning of the process of the institutionalization of the NHA. It was stated that there is a political consent to the institutionalization of NHA and more detailed steps were outlined.

Hospital Reform

- From January 10th till 25th Dr. Emil Manov and Dr. Doncho Lisiiski participated as observers in training on "Integration of Hospital Services". The training was held in USA, West Virginia
- The training on integration of hospital services was held in West Virginia, US. It was initiated by the Bulgarian Health Project, organized by World Learning and sponsored by USAID-Bulgaria. The Health Project selected and invited nine governmental employees engaged in the actual health reform and two mayors. The main idea was to train people who will be involved in the future hospital restructuring in pilot regions that were preliminary chosen. The project nominated two observers, which accompanied the group of Bulgarian officials during the training.

  Thanks to the organizers of the training the program was flexible and additional meetings were organized according to the specific interests of the trainees. There was also entertainment program for the participants.

  The first week was spent the in the city of Charleston, which is the capital of the State. During that week we had the opportunity to meet representatives from all institutions related to healthcare:
  - The main provider - the Charleston Area Medical Center (CAMC), WV hospital association,
  - State WV Medical Association,
  - the Chair of the Senate Health Committee
  - WV Healthcare Authority
  - Office of Community and Rural Health Services
  - Governor's Secretary for Health and Human Services

- Clinical coordinator of Health Rights
- News reporter for the Health Section in Charleston Gazette.

The second week was focused mainly on the healthcare providers in rural areas and how they manage with duplication of services. The trainees also visited nursing homes and one private (for profit) hospital. The main facilities that were visited were:
Princeton Community Hospital and Healthcare Center and Nursing Home
Bluefield Regional Medical Center
Tazewell Community Hospital
Bluefield Daily Telegraph
Representative of private insurance companies

The every day program was intense and took approximately eight hours.
As an outcome from the training all participants in accordance with their position had to develop action plans to be implemented with their return back in Bulgaria.

ANNEX 1

PRIORITIES IN THE WORK OF THE MINISTRY OF HEALTH AND USAID "BULGARIA HEALTH REFORM PROJECT" FOR 2004

At a meeting, held on 9 January 2004, Dr. Petko Salchev, deputy minister of health, and Mr. Ibrahim Shehata, COP "Bulgaria Health Reform Project" (BHRP), discussed the priorities in the work of the MoH and BHRP for 2004. The following topics and future steps were agreed on:

1. **Hospital reform**
   - finishing the report for Lovech region
   - finalize the assessment for Stara Zagora region (March 2004)
   - preparation for assessment in Razgad region
   - beginning preparation for the implementation in 2 regions (the end of 2004)

2. **DRGs**
   - initiate data collection and training of trainers
   - general evaluation of the process of the implementation of DRG
   - regular evaluation and report to the Minister of Health and the Chairman of the Managing Board of the NHIF for the execution of the Agreement for distribution of responsibilities for the implementation of DRGs between MoH and NHIF (February, September)
   - future collaboration with NHIF for simultaneous implementation of DRGs and ICD-10

3. **Institutionalization of National Health Accounts**
   - collaboration with the Health Commission at the National Assembly for developing (at decision-making level) the future steps needed for the institutionalization of NHA (legal documents, responsible institutions, training, etc.)
   - the National Center for Public Health will take methodological guidance over the expert work for the institutionalization of NHA

4. **Benefit Package & Co-payment**
   - discussions and seminars with representatives of the Health Commission at the National Assembly, Ministry of Finance, Ministry of Labor and Social Policy, voluntary health insurance funds (i.e. a seminar on the comperative analyses of different systems – March)

Dr. Petko Salchev
Deputy minister of health

Ibrahim Shehata
COP "Bulgaria Health Reform Project"

BULGARIA HEALTH REFORM PROJECT

Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810

FEBRUARY 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

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USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 8
February, 2004

Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
Contract Number:	PCE-I-00-00-00014-00
Task Order:	810
Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

Inpatient Care Financing

- Jugna Shah, a DRG advisor for BHRP had her second week of her stay in Bulgaria.

  She met with the acting director of the NHIF Dr. Bukarev and updated him with the progress made so far of the technical working group. Dr. Bukarev agreed that is very important to have number of decisions taken form the decision-maker, so to move forward on the timeline. He promised his support to the national implementation plan of the new finance system

  The beginning of the week was spent on putting together the materials for the working meeting. Mrs. Shah had number of meeting with representatives of the technical working group and to have every one on the same page. She observed the evaluation paper for the different options of procedure coding systems and the recommendations of the experts. The BHRP prepared a folder for the meeting.

  Mrs. Shah was asked to be the facilitator of the meeting.

- On the February 5th a meeting of the decision-makers and the technical group responsible for the implementation of DRGs was held in the Ministry of Health. The attendants were Dr. A. Shterev, Chairman of the Parliamentary Health Commission, Dr. P. Salchev, Deputy Minister of Health, Dr. I. Boukarev, Director of the NHIF, Mr. T. Vassilev, Deputy Director of the NHIF, Mrs. J. Nacheva, NHIF, Dr. K. Chenkova, MoH, Dr. Y. Drenski – Chairman of the Working group. Representatives from the World Bank, 3M, USAID and BHRP were invited at the meeting. The main topics discussed were:
  - The update on the DRG Implementation Roadmap and the Current DRG 3M/WB Pilot Project;
  - Review and Discussion of the Working Group's Recommendation for a New Procedure Coding System for Implementation in Bulgaria;
  - Holding a Retreat Outside of Sofia with the Technical Working Group and the Decision-Makers to Move Forward with the Roadmap.

  The decision-makers came up with a decision on procedure coding system ICD-9-CM.

A paper was prepared and signed with a language about the chosen procedures. It was signed by Dr.Shterev, Dr.Salchev and Dr.Boukarev. (Annex 1)

National Health Accounts

- Ibrahim Shehata presented to deputy minister Salshev and the chairman of the parliamentary health commission, Dr. Shterev a framework for institutionalizing NHA in Bulgaria. The framework is attached in Annex 2.

Hospital Reform

- The BHP team continued and finished the assessment of the health care facilities in the Stara Zagora region. The regional assessment for Stara Zagora was conducted by a team of medical and financial specialists over the course of six months. The team visited every hospital in the region multiple times (with the exception of psychiatric facilities which are not part of this assessment), and conducted interviews with hospitals management, departmental managers, and other staff who were available to provide their input. We worked closely with the Regional Health Center to collect data and obtain additional insights regarding healthcare services in the region, with emphasis on the hospitals.

ANNEX 1

DECISION
FOR SELECTION OF PROCEDURES' CODING SYSTEM
FOR THE PUSPOSES OF IMPLEMENTING DRGS AS
A HOSPITAL PAYMENT TOOL IN BULGARIA

At a meeting of the Decision-making group consisting of Dr. Salchev, Deputy Minister, Dr. I. Boukarev, Director, NHIF and Dr. A. Shterev, Chairman, Parliamentary Health Commission held on February 5, 2004 the following decision was made:

After conducting consultations and a profound study of the materials provided and hearing the Technical Working Group's recommendations regarding various modifications of procedures' coding systems, it was decided to implement ICD-9-CM in all inpatient care facilities in Bulgaria. The selection was based on the following facts:

- ICD-9-CM is translated into Bulgarian and ready for print
- No payment of copyrights required
- Free grouper available
- Free annual update
- Considerable number of training materials and trainers available. Bulgarian trainers also available
- Substantial experience with coding under ICD-9-CM
- Fast to implement and apply in Bulgaria

The MoH will draft an Order to all hospital managers informing them about the adoption of the new system for coding diagnoses and procedures.

NHIF will be responsible to prepare tentative schedule for developing national training program.

This Decision was drafted in 3 identical copies, one for each party.

February 5th, 2004г.

NATIONAL HEALTH ACCOUNTS

What are National Health Accounts?

NHA is a tool aimed primarily at policy makers to enable better-informed decisions regarding health planning, financing, and evaluation. NHA describes the sources, uses, and flow of funds – both by public and private entities – within the health sector. In essence, NHA assists health care decision makers with understanding who pays, how much and for what.

NHA are presented using a set of international standard tables developed by the Organization for Economic Cooperation and Development (OECD) in which various aspects of a nation's health expenditures are described. The NHA standard tables have been designed to provide health expenditure information to policy makers in ways that can be clearly and directly linked to a nation's health policy financing concerns and issues. Some of the key questions to which policy-makers need answers for sound stewardship.

- ***How are resources mobilized for the health system?*** This is an important question both for evaluating health system results and for developing strategies to improve performance. Knowing on whom the burden of financing falls and how large it is relative to their means illuminates financial protection and fairness of financial burden. Knowing who contributes to health spending is valuable information in designing policies and interventions. In addition, it is a key determinant of how much resources (in financial terms) are available to the health system. Answers to this question provide the basis for thinking about strategies to increase the resources available as well as efforts to change who in the population bears the burden of financing health.
- ***How are resources managed?*** Cover several important areas of health policy and reform. First, what types of social structures in the public and private sector have been created to raise funds and organize and pool those funds to pay for the production of health goods and services? How well and fairly do those arrangements pool risks across the population? How do institutions that pay for or purchase health care pay providers and with what effect?
- ***How are health funds distributed across the different services and activities?*** The commitment of health resources to health functions is one valuable measure of the actual priorities of a health system. What share of spending is claimed by collective public health interventions relative to inpatient services, or by interventions for infectious disease relative to maternal health or cardiovascular conditions? Measures like these are also excellent indicators of whether policies to shift resource priorities are working. NHA can also contribute to the analysis of cost-effectiveness and health service efficiency, by linking expenditures with health outputs and outcomes.
- ***Who benefits?*** *C*an be answered according to a variety of different dimensions of beneficiaries including income groups, age/sex groups, geographic regions, and

health problems. Answers to this question address the important health system goal of distributional fairness.

To answer these questions and many more, NHA has been designed around the concept of the *flow of financing* in the health system (see Figure 1).

The flow of financing concept highlights an important aspect of NHA. Financial resources flow through the health system over time and may be enabling different health system activities at different points in time. Describing the composition of these funds at different points in the flow of financing is what allows NHA to address so many useful policy questions. For example, when NHA tables estimate total health expenditure in a country during a year, this quantity of expenditure may be registered at different places in the flow of financing during the year, associated with different activities. Initially, funds may be mobilized as revenues from government taxation, payments of health insurance premiums by households and employers, or household incomes allocated to health. These funds may then be pooled in different institutions, such as the Ministry of Health and social and private health insurance funds or used directly by households and firms to purchase health care goods and services in the market. These institutions act as intermediary financing agents using the funds mobilized from specific sources. They also act as purchasers or payers for health goods and services, when they transfer funds to providers as payment for or to enable them to produce specific types of goods and services. Further, the value of these goods and services can be attributed to different groups in the population as measures of distribution. In all of these examples, the same annual total expenditure can be tabulated in different ways to address important policy questions.

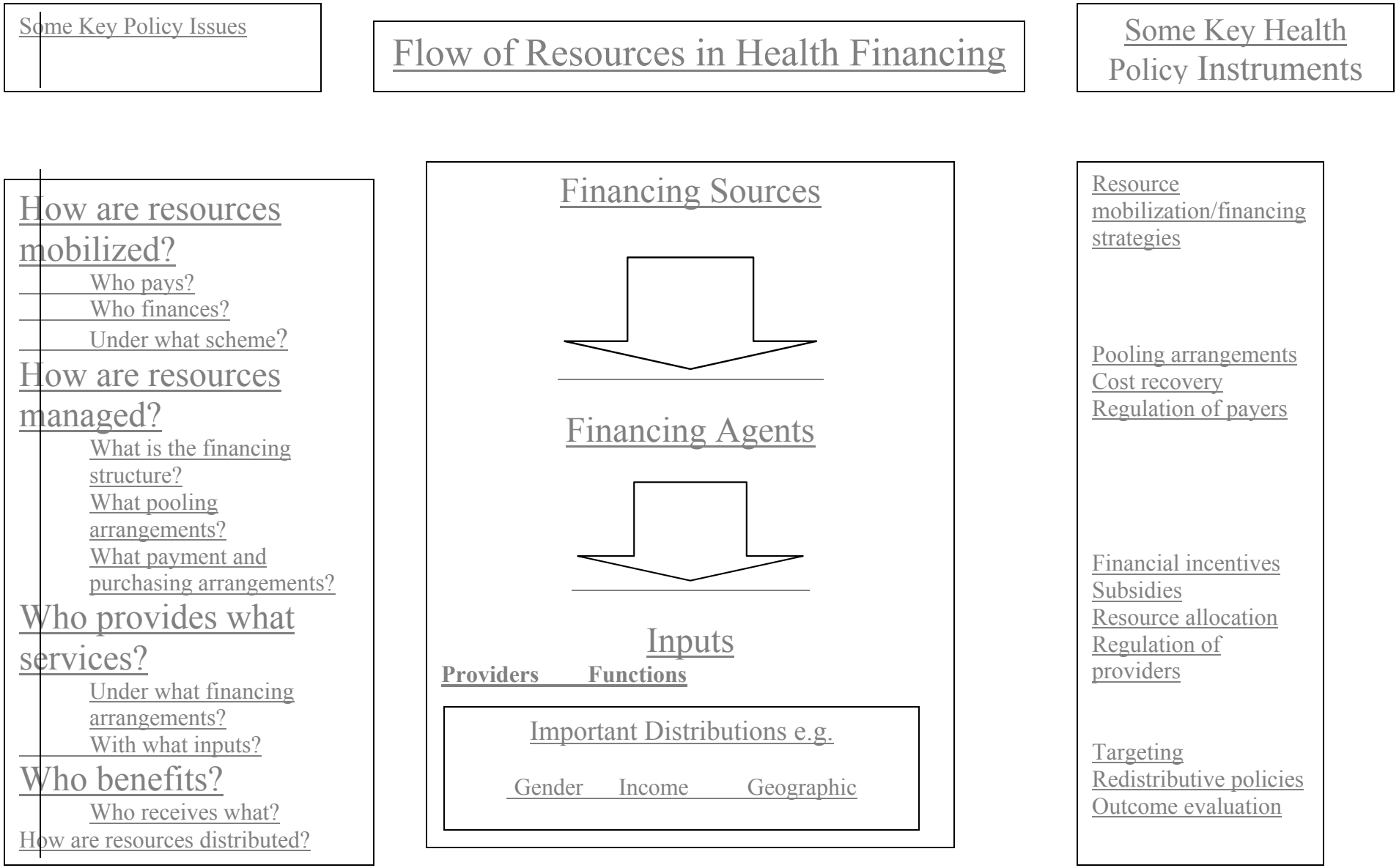
Why Develop National Health Accounts?

Health financing evidence can contribute to improved performance. Financing information is an essential input for strengthening policies to improve health systems functioning. It also contributes to the measurement of the outcomes of the system and the factors that explain these outcomes. What distinguishes NHA from other forms of expenditure review are one or more of the following:

A rigorous classification of the types and purposes of expenditures and of the actors in the health system;
A complete accounting of all spending for health, regardless of the origin, destination, or object of the expenditure;
A rigorous approach to collecting, cataloging, and estimating those flows of money; and
A structure intended for ongoing analysis as opposed to one-time study.

Figure 1

How NHA Presents Financing Flows and Links to Health Policy Decisions



How Can We Institutionalize NHA in Bulgaria?
Institutionalization of NHA means that the activities of collecting, analyzing and reporting total health care spending is systemized to the point where it is undertaken routinely by a designated entity/department which follows a predetermined standards and protocols.

Institutionalizing NHA should be looked at as a government responsibility that ought to be enveloped into the government routine processes with the objective of forming a core dataset for health policy development, monitoring and evaluation. This implies that for NHA to become a consistent activity it should meet two principles:

a) Become a core activity within the entity responsible for producing it; and
b) Be closely linked to policy requirements in order to be useful.

The main institutionalization activities are focused around the changes in how data is being compiled and reported nationally. In the short-term, defining the component tasks and building the needed technical capacity for executing NHA will be the focus.

An environment that enables the initiation, growth, and sustainability of the NHA activities must incorporate supportive policies, standardized methods for data reporting, effective leadership and adequate resource allocation which emphasizes the importance of NHA as a policy planning tool. To that extent, the essential elements fundamental to the successful institutionalization of national health accounts are:

a) Housing NHA,
b) Standards for Data Collection, and;
c) Requirements for data reporting.

Funding NHA in Bulgaria
Most of the cost involved with implementing and sustaining NHA in Bulgaria are related to providing the necessary technical assistance and training of staff. These are being offered by the USAID funded health Reform Project. Data compilation will have to be coordinated with the various entities such as the National Statistics Institute to eliminate any duplication and reduce costs. If the institutions collaborating on NHA contribute resources in kind, such as their staff, computers, and space, the additional budgetary costs can be very modest if Bulgaria is committed to producing the NHA on an ongoing basis, the cost of sustaining NHA within government institutions is modest, as it becomes a routine part of economic analysis.

BULGARIA HEALTH REFORM PROJECT

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Task Order 810

MARCH 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

Prepared by:

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USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 9
March, 2004

Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
Contract Number:	PCE-I-00-00-00014-00
Task Order:	810
Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

General

- The Parliament discussed at first reading eight proposals for amendment of the Health Insurance Act, most of which concerning the deadline for the health insurance payments. The proposal for a drastic change in the management of the NHIF (the Director and the Deputy director of the NHIF to be chosen from the Parliament, the competence of the Director to be expanded in comparison with the current situation) was rejected.
- The deadline for submitting the documents for the position of Director of the NHIF has expired. Only one candidate submitted his documents and more likely it is Dr. Bukarev, the acting Director of the NHIF. A committee will consider the applications and make a choice in the beginning of April.

Inpatient Care Financing

- Mrs. Jugna Shah, a DRG advisor for BHRP, arrived in Bulgaria for 1 1/2 weeks on 14 March through the 23rd to continue the technical assistance to the interested institutions with their plan to move towards a case-based payment scheme based on DRGs. SOW during her stay was to prepare and to moderate a meeting of the decision-makers out of Sofia – 20-21 March. The first week of her stay was devoted to meeting with counterparts in order to get them together and to get them on the same page in terms of discussions. Mrs. Shah met with the acting Director of the NHIF Dr. Bukarev to discuss what the following steps and decisions that need to be taken in order to move with the case - based payment system are. Mrs. Shah also met with Dr. Drenski to discuss the progress made with the data receiving from the pilot project hospitals. The BHRP and NHIF experts had a week of preparing the materials for the meeting in Velingrad.
  Mrs. Shah met Dr. Shterev and Dr. Kehayov on the way to get all representatives from the interested institution on the table for a discussion on the DRGs implementation process. She met also Mrs. Elizabeth Moss from HIMAA who are willing to help with evaluating the selection of coders to be trained.

Mrs. Shah left behind three new timelines of the implementation process and an optional paper of Simulating Hospital Budgets under the Case-based Financing.

- The meeting was handled in Velingrad, Bulgaria. It was attended by Dr. Shterev, chairman of the Parliamentary Health Commission, Dr. Tzekov, member of the Parliamentary Health Commission, Mr. Bogoev, Minister of Health, Dr. Salchev, Deputy minister of Health, Dr. Bukarev, acting Director of the NHIF, Mr. Theodor Vassilev, Deputy director of the NHIF, Dr. Kehayov, Head of the Bulgarian Physician Union, representatives from the MoH, MoF, NHIF, USAID and BHRP, PMU/WB, 3M Company. The meeting was organized and facilitated by the BHRP.
- Questions regarding accelerating the implementation timeline of the Case – based financing mechanism in Bulgaria were discussed during the meeting. The decision – makers came up with an agreement on the following issues:

  1. All participants agreed that the base of the implementation process is the clinical data collection, which is crucial for any financing mechanism. They all agreed to go ahead with the implementation of the case-based system/DRGs
  2. Parliamentary health commission, MoH and the NHIF agreed that the accelerated timeline is doable, and are ready to work towards this to complete with the preparation for national implementation by the end of 2004
  3. The decision-makers are ready to meet on a regular bases, every two weeks, to discuss technical issues presented by the working group and to make policy decisions on specific issues in order to move forward with the timeline
  4. The NHIF is ready and willing to begin a pilot financing implementation using DRGs in 2005. According to that the decision maker have to have in consideration the negotiations for the National Framework Contract for the next year. The Physicians Union has to be more involved in the discussions.
  5. All participants agreed that the most important issue on this stage of the implementation process is to provide training on coding to all Bulgarian hospitals. That has to be done as soon as possible. The technical group needs to present a draft paper of the national training program in two weeks period
- The next step to move forward is to provide the decision-makers with evaluation paper of the possible software groupers and to make a decision of one and to go further with the purchasing procedure.
- In the second part of March BHRP worked with the NHIF experts to prepare the materials required from the decision-makers to develop a National Training Program.

Hospital Reform

- The BHRP team started writing the final report for the hospital assessment in the Stara Zagora region. Bill Lane, a BHRP consultant, arrived in Bulgaria to assist the BHRP team with data analysis from the Stara Zagora region as well as preparing the final hospital assessment report for the region. The objectives of the the assessment was to:

- Compile community profile information including population by age and demographic characteristics of each municipality.
- Understand health services needs by assessing morbidity, mortality and health status of the population in each municipality.
- Determine any unmet community health needs and prioritize them if possible.
- Examine standard financial reports such as operating costs, capital expenditures, profit and loss statement, balance sheet, cash flow, etc.
- Understand the main problems the hospitals are facing; examine the nature of their relationship with MOH, NHIF and other local authorities.
- Assess alternative sources of patient care and the impact on provision and utilization.
- Recommend practical solutions for hospitals' restructuring.

National Health Accounts

- BHRP prepared a document on the basic policy aspects of the NHA for Dr. Shterev, Chairman of the Parliamentary Health commission. Dr. Shterev intends to meet informally with key policy makers and to present to them the idea of the institutionalization of the system of the NHA in Bulgaria.
- Institutionalization of NHA means that the activities of collecting, analyzing and reporting total health care spending is systemized to the point where it is undertaken routinely by a designated entity/department which follows a predetermined standards and protocols.

  Institutionalizing NHA should be looked at as a government responsibility that ought to be enveloped into the government routine processes with the objective of forming a core dataset for health policy development, monitoring and evaluation. This implies that for NHA to become a consistent activity it should meet two principles:

  a) Become a core activity within the entity responsible for producing it; and
  b) Be closely linked to policy requirements in order to be useful.

- The main institutionalization activities are focused around the changes in how data is being compiled and reported nationally. In the short-term, defining the component tasks and building the needed technical capacity for executing NHA will be the focus.

  An environment that enables the initiation, growth, and sustainability of the NHA activities must incorporate supportive policies, standardized methods for data reporting, effective leadership and adequate resource allocation which emphasizes the importance of NHA as a policy planning tool. To that extent, the essential elements fundamental to the successful institutionalization of national health accounts are:

a) Housing NHA,
b) Standards for Data Collection, and;
c) Requirements for data reporting.

- Most of the cost involved with implementing and sustaining NHA in Bulgaria are related to providing the necessary technical assistance and training of staff. These are being offered by the USAID funded health Reform Project. Data compilation will have to be coordinated with the various entities such as the National Statistics Institute to eliminate any duplication and reduce costs. If the institutions collaborating on NHA contribute resources in kind, such as their staff, computers, and space, the additional budgetary costs can be very modest if Bulgaria is committed to producing the NHA on an ongoing basis, the cost of sustaining NHA within government institutions is modest, as it becomes a routine part of economic analysis.

BULGARIA HEALTH REFORM PROJECT

Contract № PCE – I – 00 – 00 – 00014 – 00
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APRIL 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

Prepared by:

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USAID HEALTH PROJECT SUMMARY AND REPORT
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Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
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Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

General

- Dr. Ivan Bukarev was officially named the new Director of the National Health Insurance Fund on April 5th. He was acting Director of the NHIF since January 2004, when the previous Director Dr. Petrov was removed from office.
- The BHR team prepared the Executive Summary for the Hospital Assessment for Stara Zagora region with some key findings, main problems and recommendations for health care in Stara Zagora region.
- The decision makers group approved the National Training Program for the national implementation of the DRGs in Bulgaria.

Inpatient Care Financing

- BHR and the technical team worked together to develop a draft of the National Training Program (NTP) for the national implementation of the DRGs in Bulgaria (see Annex 1). The NTP was the main topic of the decision makers meeting carried out on the 9th of April at the NHIF. The meeting was attended by all related institution representatives: the Chairman of the Parliamentary Health Commission Dr. Atanas Sterev, the Minister of Health Mr. Slavcho Bogoev, the deputy Minister of Finance and Chairman of the Board of the Directors of NHIF Mr. Kiril Ananiev, the new Director of the NHIF Dr. Ivan Bukarev, the deputy Director of NHIF Mr. Teodor Vasilev, Mrs. Evgenia Delcheva – the Head of the AMOD department of the NHIF, and also members of the technical working team: Dr. Yavor Drenski – the chairman of the group and the case-mix office, Mrs. Jeni Nacheva – budget director of NHIF, Dr. Cristian Griva – Director of NCHI, Dr. Michaela Mihailova – PMU/WB Director, Mr. Ibrahim Shehata – COP of the BHP and Mrs. Assia Toumbanova – BHR Coordinator.
  Everybody unanimously accepted the presented time schedule of the program. The Minister of Heath asked the PMU Director to start the preparations of the WB procedure for issuing finances on this project. The COP of the BHR suggested option for co-financing between WB, loan financing, and Georgetown University, which will provide a grant financing. Mr. Shehata said

that BHR had received confirmation from Georgetown University/USAID of their will to cover the international experts provision. The idea was very well accepted.
The discussion moved to the second topic of the meeting that was observation of the presented material of the software grouper options. The presented paper was giving just information of the current usage of the groupers by countries that are using the DRG method of financing. The grouper selection will be a subject of the next decision makers meeting.

- BHR, PMU and NHIF experts worked to provide the details of the NTP. That includes financing differentiation and trainers CVs evaluation. All observations shall be completed by the end of May. That recalls designing of curriculum of the training and creation of the requirement to the international trainers.
- BHR was looking to provide information to the case-mix office on receiving research licenses of the software groper options.
- BHP continued with their assistance to NHIF on their way to design their future work.

Hospital Reform

- Mr. William Lane, a BHR consultant, continued his stay in Bulgaria to help the BHR team finish the report for Hospital Assessment for Stara Zagora region.
- The BHR team prepared the Executive Summary for the Hospital Assessment for Stara Zagora region. The Executive Summary addresses some key regional findings about Stara Zagora region, like oversupply of outpatient and inpatient healthcare professionals and facilities in the city of Stara Zagora and insufficient supply of outpatient general and specialized practices in remote municipalities; patients present at the hospitals in advanced stages of illness or injury that could have been addressed more easily and more inexpensively with proper preventive healthcare services; duplication of healthcare services provided by health care institutions as well as by departments within the same facility; inadequate staffing of Emergency Care Centers; absence of alternative healthcare facilities. The Executive Summary includes recommendations about the legal matters, clinical services, management and financing such as a legislative amendment to be enacted so that municipal hospitals may be registered not only as trade companies but also as not-for-profit companies; the requirement for a minimum of 10 beds per department to be rescinded so that the beds in municipal hospitals may be used in a manner best suited for the healthcare needs of the local population; MoH, as the regulatory authority, to mandate the introduction of alternative methods of specialization and continuous medical training; an independent medical audit structure to be created to monitor the quality of medical services in outpatient and inpatient care; permitting a co-payment to the CCPs (or whatever methodology is used in the future) by the patient or the VHIFs in order to enhance the basic benefit package and compensate for the difference between the hospital's own price for the medical service and the amount the NHIF will reimburse under the CCP agreement; to alter the primary care/ambulatory care payment methodology in villages and hard to reach/remote areas, and regions with predominantly minority populations; to design and implement a national healthcare information system integrating the data that the MoH, NHIF, hospitals, and independent university researchers need, submitted by all healthcare providers.

- The Executive Summary (see Annex 1) was presented to the senior officials at the MoH, including Mr. Slavcho Bogoev, Minister of Health, Dr. Petko Salchev, Deputy Minister of Health and Mrs. Valeria Ivanova, the Head of the Political Cabinet of the Minister.

ANNEX 2

Executive Summary

Overview

The regional assessment for Stara Zagora was conducted by a team of medical and financial specialists over the course of six months. The team visited every hospital in the region multiple times (with the exception of psychiatric facilities which are not part of this assessment), and conducted interviews with hospitals management, departmental managers, and other staff who were available to provide their input. We worked closely with the Regional Health Center to collect data and obtain additional insights regarding healthcare services in the region, with emphasis on the hospitals.

Key Regional Findings

Below are some of the findings specific to the region that impact demand and access to the healthcare services. Later we present findings and recommendations concerning the structure and management of the overall healthcare system. We believe that addressing the region-specific matters alone is not sufficient to enhance healthcare in the region because it does not operate in a vacuum. These key findings are important because they are based on data and observations for the region itself.

- Oversupply of outpatient and inpatient healthcare professionals and facilities in the city of Stara Zagora. By contrast, there is shortage of outpatient, general and specialized practices in remote municipalities which leads to patients having to travel to the nearest municipal hospital, which is often unnecessary.
- Lack of regular public transportation between remote villages and municipal centers. This factor is a barrier to accessing needed healthcare services by those who do not have their own means of transportation.
- In cases where significant travel is not needed to access healthcare services, there still seems to be inadequate outpatient care. According to those interviewed for this assessment, patients present at the hospitals in advanced stages of illness or injury that could have been addressed more easily and less expensively with proper preventive healthcare services. This issue is partly attributable to the health seeking behaviors of the population – they may not understand the benefits of preventive care or they might not be able to "afford" to seek care by taking time away from work – and partly attributable to the healthcare system where there doesn't seem to be any accountability concerning the provision of outpatient or preventive healthcare services. This phenomenon leads to excessive utilization of inpatient care.
- Duplication of healthcare services provided by different health care institutions as well as by departments within the same facility. Part of this problem is the provision of health care services outside a facility's mandated scope in order to compete in the "for-profit" environment; this is especially true of the University Hospital and the dispensaries. Particularly redundant is the existence of two functioning MHATs – the University Hospital and the Regional Hospital, sharing the same buildings. The best solution to this anomaly would be to build a new hospital, consolidate the duplicative departments from each of the existing facilities, and raze the existing buildings. It would be reasonable to compare the efficiency of building a new facility versus renovating the old ones
- Since 2000 there has been a dramatic increase of primary disability. Occupational health and disability assessments should be conducted to identify the causes for this trend and implement programs to reverse or mitigate it.

- Inadequate staffing of Emergency Care Centers – some emergency care branches only employ nurses and paramedics and no physicians despite the fact these branches are the only health care facility in the area working round the clock. Proper emergency care provided immediately can prevent some injuries or illnesses from becoming more complicated and more expensive cases to treat.
- Absence of alternative healthcare facilities such as hospices, long-term care, and skilled nursing care facilities, and other ancillary healthcare providers. These types of facilities provide a level of care for people who cannot otherwise continue to reside at home, and at lower cost than an acute inpatient care facility.
- Referrals of emergency cases from municipal hospitals to the Regional or the University Hospital are completed only after mandatory consultation with the relevant national consultant, though this is not specified with in MoH's Regulation No. 26/1996 on consultative health care and the interaction between health care facilities. This additional requirement unnecessarily delays the provision of health care services.
- Demographic and socioeconomic indicators – the population is aging and there are an increasing percentage of ethnic minorities, especially in small municipalities and rural areas. Increased outreach to targeted segments of the population can help improve health status and lower morbidity in the area.
- Industrial dust contamination in the southern part of the region causing an increase in respiratory illnesses.

Key Findings with the Healthcare System

Oversight

The organization and oversight of medical activities in Bulgaria is not unified – outpatient care is regulated primarily by the NHIF in its role as a financing institution, whereas the MoH, NHIF, and/or the municipal authorities manage inpatient care, depending on the type of ownership and/or financing. Emergency care is entirely subject to the MoH because it is considered a state priority. This variation has contributed to a healthcare system that is not integrated. To its credit, the current Bulgarian government is taking steps to rationalize the system to make it more harmonious with those of its European neighbors. This is important as the country looks forward to EU accession in the near future.

When developing or implementing policy, such as CCPs, DRGs, and other issues of concern to the healthcare system, it is imperative that all stakeholders be involved. For instance, the national framework contract involves negotiations between the NHIF and the Physicians Union. However, the hospitals are not represented as a party in the negotiations and when physicians negotiate with the NHIF on behalf of the hospitals, it is only logical that their focus is physician compensation and not the physical state of the hospital. In order for physicians to perform their duties well, the hospitals must provide a suitable clinical environment – working elevators, adequate heat and lighting, hot water and other often overlooked items.

Legal & Regulatory Matters

All hospitals, regardless of their scope of activity, have been registered as commercial entities under the Commercial Act, which leads to unfair, and often ill-advised, competition among themselves rather than complementing each other as part of an integrated system. Each commercial entity sees its mission in the maximization of the number and type of services and that results in duplication and overlapping service areas.

Bulgaria should enact a legislative amendment so that municipal hospitals may be registered not only as trade companies but also as not-for-profit companies. Thus, hospitals will have incentives to work more efficiently, to realize profit that they can reinvest in the hospital (buildings and equipment) or its services. In each of the hospitals a board of trustees should be established whose members are different than the municipal council but have broad community representation. The tasks and objectives of the trustees would

be to help define the strategy for the healthcare facility's development; recruit, hire, and monitor employee performance and remuneration; find additional sources of financing; review and authorize proposed investments in equipment and buildings; and solicit feedback from citizens in the service area.

The State should create a regulatory option for ambulatory care specialists to contract with hospitals to admit patients and use the hospital equipment. This would be helpful for municipal hospitals, which have financial difficulty having both employed specialists on payroll and adequate funds for the necessary specialized equipment. In this way, the hospital could have specialists work part-time on a contract basis, providing needed healthcare services to patients in the area. Patients would not be inconvenienced by having to travel large distances to other cities for treatment.

Dispensaries should be defined as centers for the provision of ambulatory services, including pro-active interventions through community outreach, education activities among the population, the GPs and the ambulatory specialists, as well as diagnostics, treatment and monitoring of the four groups of diseases. The MoH, as part of its health promotion strategy, should finance screening and educational activities, and the NHIF would reimburse the dispensaries for diagnostic, treatment, and monitoring activities. The dispensaries, as ambulatory units, should be owned entirely by the State, to avoid any conflicts such as the existing municipal ownership but a regional service area. Their activities should be monitored by the RHC. The dispensaries should also not maintain Disability Assessment Commissions.

The Disability Assessment Commissions should be independent outpatient facilities, administered and funded separately by the State.

Management

Apparently, hospital directors face certain administrative restrictions in making complex managerial decisions that aim to optimize hospital operations. Any structural reform, like laying off staff, closing beds, moving or merging beds, isolating space, renting out space, buildings or equipment, requires administrative approval from various institutions – the MoH, municipal authorities, etc.. The Healthcare Establishments Act does not permit municipal hospitals to be registered as hospitals for active treatment, if they had less than four departments. The legal requirement for a minimum of 10 beds per department should be rescinded so that the beds in municipal hospitals may be used in a manner best suited for the healthcare needs of the local population rather than based on rigidly enforced assignments by department.

On an annual basis, municipalities and hospitals' board of trustees should be required to prepare a detailed healthcare and social strategy for the specific needs of their populations. Likewise, the financing of that strategy should be reflected in the draft budget for each year. A process like this could allow municipalities the discretion to fund and implement preventive healthcare programs designed to address targeted issues facing the community.

In connection with the cancellation of the regional principle and the introduction of free access to healthcare services by patients, the rights and obligations of all the municipalities in the Stara Zagora region should be adjusted in connection with their shares in the ownership of the Regional Hospital. This must be done through the mediation of the governor, the director of the RHC, and the participation of the director of the Regional Hospital, and the mayors of all concerned municipalities. If necessary, the ownership of the Regional Hospital must be changed or registered in another form so that only those municipalities that have so chosen will be shareholders.

The ordinance of the Hygiene and Epidemiology Institute concerning sanitary and hygiene requirements and the organization of infectious diseases departments should permit the establishment and funding, if necessary, of infectious diseases sectors in the hospitals, which are to use the beds based on healthcare

needs. This will avoid the requirement to have a permanent, separate ward for infectious diseases – allowing the hospitals to maximize the utility of their premises.

MoH, as the regulatory authority, should mandate the introduction of alternative methods of specialization and continuous medical training, including distance learning, on-line training, tele-medicine, seminars and lectures on-site, correspondent courses. This should be done in a manner that would minimize absences from work and, therefore, improving the availability of healthcare services.

Alternative Healthcare Establishments

Bulgaria should create alternative healthcare establishments (sometimes referred to as ancillary healthcare providers), such as adult day care or home health care, skilled nursing care homes, and hospices, following a careful analysis of the needs of each municipality. The NHIF, MoH, Ministry of Labor and Social Policy, municipalities, university experts, and voluntary health insurers should develop and cost a methodology for financing such institutions.

An important institutional development would be the creation of ambulatory surgical centers, whether within an existing hospital or at a stand-alone facility. Not all surgical interventions require an overnight admission, and ambulatory surgery should be considered to reduce costs and improve health system efficiency.

Hospices should be included as a type of ancillary healthcare provider in the RHC's statistical report. Legislation should authorize and regulate these facilities, their activities and relationships with other types of healthcare facilities, the GPs and the ambulatory care specialists. The MoH should establish a common framework for the activity of the hospices.

Clinical Services

The network of hospitals needs to be streamlined to be consistent with the actual healthcare needs of the population in terms of services provided and number of acute beds per 1,000 people. Given the demographic profile of Stara Zagora region, the total number of admissions per year should be close to 34,000. However, the actual number of reported discharges in 2002 was approximately 60,000, about 76 percent more than the estimated number. The Stara Zagora region currently has an overall capacity of 1,973 beds. Assuming a realistic ALOS of 8 days and an average 80 percent bed occupancy rate, estimated 34,000 admissions could well be handled using 910 acute beds. Therefore, the number of acute beds in Stara Zagora region is twice as high as necessary.

Primary healthcare services are often provided in inpatient settings. The reasons for high inpatient utilization rates are based on the traditional health seeking behaviors of the Bulgarian people, who are used to receiving medical services in hospitals. Outpatient care has historically been inadequate and insufficient, although it is a priority of the Bulgarian government's ongoing healthcare reform efforts. The general and specialized outpatient practices are not sufficiently equipped so most diagnostic processes continue in inpatient facilities. Other issues impacting healthcare quality are the following:

- Insufficient and depreciated technical equipment;
- Substandard sanitary and living conditions in old, poorly maintained buildings;
- Poor coordination among primary care, ambulatory care, emergency care, and inpatient care, due to the lack of a common regulatory body, independent medical audit and coherent national strategy.
- In many of departments there is no 24 hours' per day duty schedule.
- Insufficient number of nurses in some of the hospitals.
- Lack of sufficient number of specialists in municipal hospitals.

- Lack of modern prescription drugs due primarily to excessive cost.

There is a high rate of re-hospitalization, needed because of the inability of pensioners, socially underprivileged, and minority groups to (1) follow treatment regimens physicians provide at the time of discharge, and (2) purchase prescription drugs due to the reduced reimbursement percentage of most common drugs by the NHIF, to the expense of the most expensive. On the matter of prescription drugs, the distribution of medicines seems to be disorganized and prone to pricing volatility. Some interviewees stated that vendors change the prices of the medicines after securing the contract to provide them. MoH and NHIF should develop model provider agreements or contracts that protect all parties from price manipulation. Because modern prescription drugs are clinically effective, the payers like NHIF and the hospitals need to have reasonable estimates for their budgeting. Arbitrary price increases only exacerbate the problem.
Many admissions lack appropriate indications for hospitalization but yet they occur because the current financial incentives and hospital evaluation methodology do not properly constrain both inpatient and outpatient care. CCPs are the first attempt at introducing standardized indications for hospitalization, but they are limited to only covering the diagnoses for which the NHIF has been able to agree to pay.
The State should mandate the creation of an independent medical audit structure to monitor the quality of medical services in outpatient and inpatient care, and the appropriateness of hospitalizations and other services, in accordance with national and international clinical practice standards. The proper execution of medical audits is only possible and efficient if there is an information system that can share data in a standardized fashion.
The RHC should have a mandate to perform monitoring and quality assurance functions for all healthcare activities overseen by the MoH, including ambulatory dispensaries, hospitals, medical-social homes, laboratories of the Hygiene and Epidemiology Institute, parasitology.
The State should finance an independent, nationwide survey and analysis on kidney dialysis to better assess the situation for patients with chronic kidney insufficiency by place of residence, as well as the number, workload, staff, and location of the hemo-dialysis network. As a result of this study, the State will be able to evaluate each of the existing dialysis centers and, if necessary, determine if new centers need to be opened. Because dialysis is a State activity, and there are dialysis departments in municipal hospitals, it is necessary for the State to independently finance the operations and maintenance of these departments in addition to any State-owned dialysis centers. Because of the specifics of their activity, hemo-dialysis centers should be independent units that may be located in a hospital, and they would have a completely independent budget, not included in the hospital budget. Other dialysis centers may be standalone facilities.
There are no clinical protocols for emergency care. Based on the interviews held with the staff and the patients, the primary care practices do not actually function as urgent care units. Such patients are served by the Emergency Care Centers and they increase the financial and administrative burden on local municipal hospitals due to the additional expenditures incurred for tests and consultations and are in most cases hospitalized. Admissions are required because under the present legal, regulatory, and financial framework:

- An admission is a justified reason for hospital expenditures; emergency, ambulatory, and urgent patients are not;
- Patients are often admitted under CCPs, and
- Emergency Care Centers lack beds for monitoring.

It is necessary to adopt national standards for emergency cases. Such standards will improve the quality and timeliness of emergency care.

The obligations related to providing care to emergency cases should be divided between the Emergency Care Center and the hospital. Emergency Care Center should preserve its obligations to provide care when paramedics' team has been called and patients' transportation. The other part of emergency care should be assigned to the hospitals where emergency departments must be established. Since emergency care is a governmental priority, then the MoH should directly finance the activities of these hospital departments, based on clinical protocols, actuarially sound pricing, and a minimum stay of less than 24 hours.

Financing

Because of the practice of distributing 40 percent of the CCP reimbursements to the staff, as is usually agreed by the hospital management and the medical council, there is an inherent conflict of interest between a hospital and its staff. Usually, the admitting department receives the main share of this "incentive" payment. The department staff, therefore, have incentives to admit as many patients as possible in order to receive higher remuneration, but the remaining 60% of CCP rates are insufficient to cover the real costs of treatment, so hospital management must somehow balance the growing financial deficit resulting from admitting patients under CCPs.

Based on previous recommendations from the USAID Health Reform Project and others, Bulgaria is currently in the process of developing and implementing an actuarially sound DRG system, on the basis of which all healthcare facilities would be financed. This is important since hospitals should not be financed based on mere historical principle, because this provides multiple disincentives for hospital management to act prudently, instead leading to many hospitalizations without appropriate indications and necessitating otherwise unjustifiable expenditures. The legal and regulatory regime should create appropriate clinical and financial incentives to support the ability of facilities to properly and adequately provide healthcare services. The entire subsidy methodology provides no incentives to improve the quality of clinical services or hospital administration. Any future subsidies from the State should be based on the hospital's performance compared to its budget and schedule of healthcare activities as decided by the board of trustees. Inevitably, there will be situations that arise beyond anyone's control, and that is what the subsidy should cover – unexpected but necessary expenditures required to continue providing quality healthcare services to the population in the area.

Revise the NHIF payment methodology for secondary examinations by ambulatory specialists, to reduce the number of hospitalizations of patients with acute or chronic diseases, so those patients can be monitored on an outpatient basis when medically appropriate.

Hospitals are not in a position to truly operate as real commercial entities as defined in the Commercial Act since they are required by law to perform a number of uncompensated functions such as emergency care, diagnostic tests, and maintain a Disability Assessment Committee (TELK). Financing for these activities should be carved out of the hospital budget and separately reimbursed by the appropriate Ministry.

CCPs are unable to cover actual costs incurred by hospitals due to (1) inefficient facilities and services; and (2) only 60 percent of the reimbursement rate is hospital revenue, the rest has to be distributed among the department staff as bonuses. Since the NHIF is paying for only a basic package of medical services, permitting a co-payment to the CCPs (or whatever methodology is used in the future) by the patient or the VHIFs in order to enhance the basic benefit package and compensate for the difference between the hospital's own price for the medical service and the amount the NHIF will reimburse under the CCP agreement.

The State should alter the primary care/ambulatory care payment methodology in villages and hard to reach/remote areas, and regions with predominantly minority populations, by introducing adequate risk

adjustment mechanisms and "difficult to staff" incentives. This would attract GPs to these regions and would provide primary and urgent care to these populations.

Hospitals have no legal basis to require additional out-of-pocket payment for the difference between the CCP reimbursement rate and the actual cost of procedures performed, but anecdotal evidence suggest that this is a common practice. Unless the new financing scheme addresses the shortfall in funding, MoH and NHIF should introduce a menu of small co-payments that would help the financial stability of the healthcare system.

Ownership

There is an inherent conflict between ownership and organizational mission for both dispensaries and some municipal hospitals. Although Stara Zagora municipality owns the three dispensaries, they provide services to the whole region, with the cancer dispensary serving even to the neighboring regions. Moreover, they provide services related to the health priorities defined by the State (see General Issues in the Dispensaries Chapter). The service areas of the Kazanlak and Chirpan hospitals include several additional municipalities while their respective municipality owns the facilities themselves. Those neighboring municipalities served by the city hospitals have not been subject to regulation concerning contribution to the upkeep of the facilities where their patients seek healthcare services.

Pursuant to the Health Care Institutions Act, all municipalities in the region own a stake in the Regional Hospital, however, they do not participate in its management.

The power of municipalities and their relations with the MoH in the allocation and management of municipal hospital property have not been regulated yet. In their role as principals, they establish medical centers and borrow equipment from the hospital thus creating well-equipped outpatient care practices by appropriating the scarce hospital equipment resources. This approach further reduces the ability of the hospital to perform CCPs and respectively increase revenues. Moving hospital equipment to outpatient care facilities decreases the quality of inpatient care services.

Technology

The Government of Bulgaria has various initiatives underway to improve the use of information technology throughout the country. Of particular important is the training and implementation of ICD-9 and ICD-10 coding methodologies to improve the standardization of data at every level of the healthcare system. As previously mentioned, there is a working group involved in the development and implementation of a DRG-based financing system. The World Bank has reserved funds to help pay for the training, equipment, and implementation of information technology initiatives.

A major problem observed is the absence of a standardized electronic data interchange to serve the purposes of the NHIF, MoH, and independent researchers. Some consequences of this are as follows:

- Inability to follow patient referrals from outpatient to inpatient care (or the reverse), which has resulted in multiple payments for the same service delivered to the same patient.
- Inability to analyze quality of care, such as reasons for admission, early readmission rate, number of admissions per year of chronic cases, and the like.
- Inability to obtain data on general morbidity. Only hospitalized morbidity is reported and this data is compromised due to the financial incentives to admit patients using available CCPs.
- Considerable administrative burden on the medical staff that detracts from time that should be used for patient visits and the provision of care.

At the present time, it is difficult to analyze the healthcare needs of the population due to the absence of reliable data on general morbidity and mortality in the region. It is imperative that the country design and implement a national healthcare information system integrating the data that the MoH, NHIF, hospitals, and independent university researchers need, submitted by all healthcare providers (ambulatory care, hospitals, and other healthcare facilities). Such a system will allow one to analyze the movement of patients within the healthcare system based on their Personal Civil Number to ensure that healthcare providers and patients are using services appropriately. The data in the system should also improve the collection and reliability of data concerning morbidity and other quantity criteria.

We recognize that the implementation of a hospital information system has been delayed because unified terms of reference have not yet been developed. If software were installed in hospitals individually, it would meet the needs of its statistics department alone without being able to format these data for the purposes of the NHIF and the MoH. Regardless of the specific software deployed, what is important is that hospitals and other healthcare facilities are able to produce data reports with elements mandated by MoH, NHIF, and other payers or authorities. These reports would standardize clinical and financial reporting and, along with initiatives elsewhere, improve the transparency of the healthcare market.

In order to have precise statistics about general morbidity, it is necessary for outpatient healthcare providers (physicians, facilities, etc.) to submit data to the RHC and so that all data, including that from hospitals, can be analyzed together. Strategic decisions about general healthcare services and specific, targeted medical interventions could then be designed based on the healthcare needs of the population.

Conclusion

The Stara Zagora region includes many positive features – proximity to the mountains and fertile land, an abundance (perhaps overabundance) of healthcare providers, and political leadership that is committed to having accessible healthcare services for people in the region's municipalities. On the other hand, certain industries and the network of major roads contribute to poor health statistics.

A combination of efforts by the State to improve the overall healthcare system and specific actions taken by regional and municipal health professionals could dramatically enhance the healthcare services in hospitals and other facilities. Designing adequate funding with proper incentives, freeing management and owners to make investments and conduct activities needed by the population, and deploying technology wisely will allow the region to efficiently and effectively identify, manage, and treat patients.

BULGARIA HEALTH REFORM PROJECT

Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810

MAY 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

Prepared by:

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USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 11
May, 2004

Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
Contract Number:	PCE-I-00-00-00014-00
Task Order:	810
Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

General

- Prof. Oleg Hinkov was appointed a Deputy Minister of Health after being a counselor of the Minister for a month. His field will be drug policy and international cooperation.

- Two different subjects asked for the Minister's retirement. First, the biggest wholesale dealer on the pharmaceutical market – Commercial League – demanded the MoH and the hospitals to pay up their debts to the firm and threatened to stop drugs delivery and start insolvency procedure for some of the hospitals. Commercial League accused the political leadership of the MoH and the Minister in particular for the current situation. The MoH, on its turn, stated that the debts were much lower and that there were other wholesale dealers on the market, so there was no risk for the patients. After a meeting the problem seemed to be resolved for now. Second, the parliamentary group "The New Time", which members used to be part of the ruling majority, announced that they would take steps to get the Minister's resignation because of the problems with the treatment of the narcotic-dependant people. Again, a meeting was held, after which the members of the parliamentary group stated they were satisfied with Minister's answers and withdrew the demand for his retirement.

- The Parliament started the second reading of the Public Health Act, which is supposed to be the new "constitution of health care".

- The National Framework Contract for 2004 (NFC 2004) has not been signed yet. Some of the members of the Managing Boards of the two main negotiating parties, the NHIF and the Bulgarian Physicians Union, assumed that NFC 2004 would not be signed at all this year and the negotiations for NFC 2005 would start in September 2004. Senior officials from the MoH announced that the MoH would promote a legislative amendment that would allow the Minister of Health to regulate and control the signing of the future NFCs.

- The BHR team assisted the MoH and the NHIF with the development and the trainers for the National Training Program

- The BHR team finished the Report for the Hospital Assessment for Stara Zagora region.

- A World Bank mission was in Bulgaria for one week of discussions with the Ministry of Health and the NHIF. The Health Project's COP was requested to meet with Mr. Enis Baris, the World Bank's health advisor for Bulgaria. The two discussed the national training program for implementing the DRG based financing and the three hospital assessments conducted by the project in Gabrovo, Lovech and Stara Zagora..

Inpatient Care Financing

- May 2004 was a month dedicated to the development of topics and designation of the trainers for the National Training Program (NTP) for the new scheme for hospital financing, based on DRGs. The importance of the NTP requires strong support from all parties in that process and BHR continued its' assistance so to have the preparations up by the end of May. A copy of the NTP is attached in Annex 1.

- The BHR also helped with the contacts with the Georgetown University, who has funds by USAID on certain projects. The University will contribute to the NTP with fully provision of the international expert participation. The COP of the BHR delivered the Case-mix office experts needs in order to have the best option trainers. The project arranged meeting between one of the proposed trainers – Dr. Adam Kozierkewich, who came for one weekend in order to get everybody on the same page about the topics and involvements of the international trainers. He met with Dr. Petko Salchev (Deputy Minister of Health), Dr. Ivan Bukarev (Director of the NHIF) and Prof. Lubomir Ivanov (Director of NCPH) to introduce them with the reached agreements with the local experts, in a meeting organized and participated by the BHR team. On that meeting Dr. Salchev introduced Prof. Ivanov as a representative of the institution who will coordinate the NTP smooth work from behalf of the MOH.

- At the end of the month the BHR received the international trainers names, approved by both parties.

- The BHR worked together with the case-mix office at the NHIF to have all materials and presentations ready and translated in both English and Bulgarian for the beginning of the NTP.

- The team of the BHR started putting together the materials for the next meeting of the decision-makers in June. Agenda of the meeting will be to introduce them with the groupers used around the world the recommendations for the best for Bulgaria options.

- The BHR continued to work on the options Bulgaria to obtaining research licenses of the software gropers from Australia and United States.

- The BHP continued with their assistance to NHIF on their way to design their future work.

Hospital Reform

- The BHR team finished the final Report for the Hospital Assessment for Stara Zagora region. The report is organized in a similar fashion to the two previous regional hospital assessments (Lovech and Gabrovo) with some modification based on the region's specifics. The report includes: review of social, demographic, and financial characteristics of the region; overview of health issues; description and analysis of the basic situation of health care supply and demand in Stara Zagora; description, analysis, and specific recommendations for each hospital and by location; general recommendations for the region. The report constitutes the BHR team's recommendations to the MoH and local authorities that can serve as the basis for further discussion and coordination of steps for the development of a strategy for inpatient care restructuring in Stara Zagora.
- A mission from the World Health Organization was in Bulgaria to discuss with the Ministry of Health hospital restructuring. The mission met with Dr. Stoyan Alexandrov and group of his experts. Ibrahim Shehata, Dontcho Lisyski and Emil Manov from the Health Project attended the meetings which focused primarily on developing a process for selecting the pilot region/s that will serve as demonstration project for restructuring.

ANNEX 1

NATIONAL TRAINING PROGRAMME 2004
FOR A CASEMIX APPROACH AND DRG FINANCING

The Program includes a set of consecutive modules scheduled regarding their specificity and the tasks associated with it, see Appendix №1 «Timeline»!

I. Training of experts from relevant institutions **– MoH, NHIF, Physicians' Union, etc.**

1. Training in coding (morbidity as per DRG and mortality).
To be delivered to: 1 representative of the Regional Health Center, RHIF, Regional Physicians' Union, Regional office of the NSSI, Regional office of the NSI – **144 trainees in total**.
Number of trainees per group – **24**
Groups to be trained – **6**
Training per group - **6 days.**
Classes per group:
- coding of morbidity – **33;**
- coding of mortality – **16.**

Total classes per group – 49.
A training course may comprise **3 parallel training groups** in 3 separate rooms.
Training courses – **2.**
Duration - **2 weeks.**

Trainers:
- NHIF (hospital coders) – **6 experts (2 trainers per group);**
- NHIC (trainer in coding of mortality) – **3 experts.**

Classes for coding of morbidity 33 classes X 2 (2 trainer per group) = 66 classes per group.
66 classes X 6 (training groups) = **396 classes for coding of morbidity**;

Classes for coding of mortality 16 classes X 3 (trainers) X 6 (groups) = **288 classes for coding od mortality**;

Total number of classes – 684

Venue – a hotel in Sofia with 3 halls seating at least 30 people each.

WEEKLY PROGRAM FOR TRAINING CODERS

ICD -10 diagnoses and ICD-9 CM for procedures

and coding of mortality

Sunday	# of classes

Time	16.00 –17.30	Briefing trainers on the Program, the curriculum, new techniques in coding, dividing trainees in groups and halls, distribution of training materials	
Monday			
	08.45 - 09.30	Opening. Distribution of materials. Presentation of the Curriculum	1
	09.30 - 10.15	DRGs – basic concept - presentation	1
	10.15 – 11.00	Structure of the coding system - presentation	1
	11.00 – 11.30	Coffeebreak	
	11.30 -13.00	Introduction and significance of coding under ICD-10 (diagnoses) and ICD-9 CM (procedures). General overview and ordering by ICD. Basic coding rules.	2
	13.00 – 14.00	Coffeebreak	
	14.00 - 14.45	Class 1 Class 3	1
	14.45-15.30	Class 2	1
	15.30-16.00	Coffeebreak	
	16.00- 17.30	Class 4 Drills	2
Tuesday			
	9.00 - 10.30	Class 5 Class 9	2
	10.30-11.00	Coffeebreak	
	11.00-12.30	Class 10 Class 11	2
	12.30-13.30	Coffeebreak	
	13.30-15.00	Class 6, 7, 8 Class 12	2
	15.00 15.30	Coffeebreak	
	15.30-17.00	Class 13 Drills	2
Сряда			
	09.00-10.30	Class 14 Class 15	2
	10.30-11.00	Coffeebreak	
	11.00-12.30	Class 16 Class 17	2
	12.30-13.30	Coffeebreak	
	13.30-15.00	Class 18 Class 19	2
	15.00-15.30	Coffeebreak	
	15.30-17.00	Class 19 Drills	2
Thursday			

	09.00- 10.30	Class 19 Class 20 Drills	2
	10.30-11.00	Coffeebreak	
	11.00-12.30	Class 21	2
	12.30-13.30	Coffeebreak	
	13.30-15.00	Coding of procedures Drills	2
	15.00-15.30	Coffeebreak	
	15.30-17.00	Test Review and analysis of test results. Closing	2

Friday – training in coding of mortality			
	09.00-10.30		2
	10.30-11.00	Coffeebreak	
	11.00-12.30		2
	12.30-13.30	Coffeebreak	
	13.30-15.00		2
	15.00-15.30	Coffeebreak	
	15.30-17.00		2
Saturday - training in coding of mortality			
	09.00-10.30		2
	10.30-11.00	Coffeebreak	
	11.00-12.30		2
	12.30-13.30	Coffeebreak	
	13.30-15.00		2
	15.00 - 15.30	Coffeebreak	
	15.30-17.00		2

2. Hospital management and accounting.
To be delivered to: 1 representative of the Regional Health Center, RHIF, Regional Physicians' Union – **84 trainees in total**

Number of trainees per group – **84**
Groups to be trained – **1**
Training per group - **3 days**
Classes per group - **24.**

Trainers:
- NHIF – 3 experts;

Total number of classes – **24;**

Venue - a hotel in Sofia with a hall seating at least 90 people.

TRAINING PROGRAM FOR HOSPITAL MANAGEMENT AND ACCOUNTING

Day 1 – Hospital management			**# of classes**
Time	08.45 - 09.00	Opening	
	09.00 - 10.00	DRG – basic concepts – Part I	2
	10.00 – 10.30	Discussion	
	10.30 – 11.00	Coffee break	
	11.00 – 12.00	DRG – basic concepts – Part II	2
	12.00 – 12.30	Discussion	
	12.30 – 14.00	Lunch break	
	14.00 – 15.00	Structure, role and responsibilities of hospital information units	2
	15.00 – 15.30	Discussion	
	15.30 – 16.00	Coffeebreak	
	16.00 – 17.00	Establishing hospital data base and control	2
	17.00 – 17.30	Discussion	
	9.00 - 10.00	DRG – tool for internal hospital management – Part I	2
	10.00 – 10.30	Discussion	
	10.30 -11.00	Coffee break	
	11.00 -12.00	DRG – tool for internal hospital management – Part II	2
	12.00 – 12.30	Discussion	
	12.30 -14.00	Lunch break	
	14.00 -15.00	Revenue and expenditure management	2
	15.00 – 15.30	Discussion	

	15.30 - 16.00	Coffee break	
	16.00 -17.00	Marketing strategies based on casemix analysis	2
	17.00 – 17.30	Discussion	
	09.00 -10.00	Step calculation of expenditures	2
	10.00 – 10.30	Discussion	
	10.30 -11.00	Coffee break	
	11.00 -12.00	Estimating expenditures by cost centers	2
	12.00 – 12.30	Discussion	
	12.30 -14.00	Lunchbreak	
	14.00 – 15.00	Grouping expenditures by type	2
	15.00 – 15.30	Discussion	
	15.30 -16.00	Coffee break	
	16.00 -17.00	Objectives and ways for computation	2
	17.00 – 17.30	Discussion	

II. Hospital training

1. Training in hospital management and accounting for hospital directors/managers and accountants

To be delivered to **640 people** (hospital directors/managers and accountant), 2 from each hospital including Medical centers and Diagnostic Consultative Centers with beds.

Number of trainees per group – **80**
Groups to be trained – **8**
Training per group - **3 days**
Classes per group - **24**
Duration - **4 weeks**

Trainers:

- **NHIF – 3 experts**

Total number of classes – **192**

Venue - a hotel in Sofia with a hall seating at least 90 people.

TRAINING PROGRAM FOR HOSPITAL MANAGEMENT AND ACCOUNTING

Day 1 – Hospital management			**# of classes**
Час	08.45 - 09.00	Opening	
Час	09.00 - 10.00	DRG – basic concepts – Part I	2
Час	10.00 – 10.30	Discussion	
Час	10.30 – 11.00	Coffee break	
Час	11.00 – 12.00	DRG – basic concepts – Part II	2
Час	12.00 – 12.30	Discussion	
Час	12.30 – 14.00	Lunch break	
Час	14.00 – 15.00	Structure, role and responsibilities of hospital information units	2
Час	15.00 – 15.30	Discussion	
Час	15.30 – 16.00	Coffee break	
Час	16.00 – 17.00	Establishing hospital data base and control	2
Час	17.00 – 17.30	Discussion	
Day 2 - Hospital management			
Час	9.00 - 10.00	DRG – tool for internal hospital management – Part I	2
Час	10.00 – 10.30	Discussion	
Час	10.30-11.00	Coffee break	
Час	11.00-12.00	DRG – tool for internal hospital management – Part II	2
Час	12.00 – 12.30	Discussion	
Час	12.30-14.00	Lunch break	
Час	14.00-15.00	Revenue and expenditure management	

Час	15.00 – 15.30	Discussion	2
Час	15.30 16.00	Coffee break	
Час	16.00-17.00	Marketing strategies based on casemix analysis	2
Час	17.00 – 17.30	Discussion	
Day 3 – Accounting			
Час	09.00-10.00	Step calculation of expenditures	2
Час	10.00 – 10.30	Discussion	
Час	10.30-11.00	Coffeebreak	
Час	11.00-12.00	Estimating expenditures by cost centers	2
Час	12.00 – 12.30	Discussion	
Час	12.30-14.00	Lunchbreak	
Час	14.00 – 15.00	Grouping expenditures by type	2
Час	15.00 – 15.30	Discussion	
Час	15.30-16.00	Coffee break	
Час	16.00-17.00	Objectives and ways for computation	2
Час	17.00 – 17.30	Discussion	

2. Training of coders for hospitals – training in coding morbidity by DRG.

To be delivered to: hospital information units staff (inpatient care specialists, nurses, obstetricians), **600 coders altogether**, 2 from each hospital including Medical centers and Diagnostic Consultative Centers with beds.

Number of trainees per group – **20**
Training groups – **30**
Training per group - **6 days**
Classes per group – **48**
A training course may comprise **3 parallel training groups** in 3 separate rooms.

Number of training courses – **10**
Duration - **10 weeks**
Trainers:
- NHIF (coders from hospitals) – **6 experts**

Учебни часове за кодиране на заболеваемост на една група 48 часа X 2 (2 обучителя на група) X 30 групи **= 2880 учебни часа**.

Total number of classes – **2,880**

Venue – a hotel in Sofia with 3 halls seating at least 20 people each.

WEEKLY PROGRAM FOR TRAINING CODERS

ICD -10 diagnoses and ICD-9 CM for procedures

and coding of mortality

Sunday			# of classes
Time	16.00 – 17.30	Briefing trainers on the Program, the curriculum, new techniques in coding, dividing trainees in groups and halls, distribution of training materials	
Monday			
	08.45 - 09.30	Opening. Distribution of materials. Presentation of the Curriculum	1
	09.30 - 10.15	DRG – basic concepts – presentation	1
	10.15 – 11.00	Структура на кодираща система - presentation	1
	11.00 – 11.30	Coffee break	
	11.30 -13.00	Introduction and significance of coding under ICD-10 (diagnoses) and ICD-9 CM (procedures). General overview and ordering by ICD. Basic coding rules.	2
	13.00 – 14.00	Coffee break	
	14.00 - 14.45	Class 1 Drills	1
	14.45-15.30	Class 3 Drills	1
	15.30-16.00	Coffee break	
	16.00- 17.30	Class 2 Drills Class 4 Drills	2
Tuesday			
	9.00 - 10.30	Class 5 Drills	2
	10.30-11.00	Coffee break	
	11.00-12.30	Class 9 Drills Class 10 Drills	2
	12.30-13.30	Coffee break	
	13.30-15.00	Class 11 Drills	2
	15.00 15.30	Coffee break	
	15.30-17.00	Class 6, 7, 8 Drills	2

Wednesday			
	09.00-10.30	Class 12 Drills	2
	10.30-11.00	Coffee break	
	11.00-12.30	Class 13 Drills	2
	12.30-13.30	Coffee break	
	13.30-15.00	Class 14 Drills	2
	15.00-15.30	Coffee break	
	15.30-17.00	Class 15 Drills	2
Thursday			
	09.00- 10.30	Class 16 Drills	2
	10.30-11.00	Coffee break	
	11.00-12.30	Class 17 Drills	2
	12.30-13.30	Coffee break	
	13.30-15.00	Class 18 Drills	2
	15.00-15.30	Coffee break	
	15.30-17.00	Class 19 Drills	2

Friday			
	09.00-10.30	Class 19 Drills	2
	10.30-11.00	Coffee break	
	11.00-12.30	Class 19 Drills	2
	12.30-13.30	Coffee break	
	13.30-15.00	Class 20 Drills	2
	15.00-15.30	Coffee break	
	15.30-17.00	Class 21 Drills	2
Saturday			
	09.00-10.30	Coding of procedures	2
	10.30-11.00	Coffee break	
	11.00-12.30	Coding of procedures Drills	2
	12.30-13.30	Coffee break	
	13.30-14.15	Test	1
	14.15-14.30	Coffee break	
	14.30-15.15	Test as per “History of disease”	1
	15.15-16.00	Checking and analysis of test results. Closing	1

III. Total number of classes for all modules (I+II) – **3,780**.

BULGARIA HEALTH REFORM PROJECT

Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810

JUNE 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

Prepared by:

BearingPoint, Inc.
74-A Bouzloudja St.
Sofia, Bulgaria

USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 12
June, 2004

Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
Contract Number:	PCE-I-00-00-00014-00
Task Order:	810
Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

General

- The DRG National Training Program started on the June 14
- Mrs. Jugna Shah arrived for two weeks from June 6 through June 19 to assist in the next decision-makers (DM) meeting and is also expected to meet with different members of the Parliamentary health Commission to further explain and build consensus among the different political directions on the rational behind the reforms in hospital financing. Mrs. Shah will assist with the comparison between the different groupers that eventually hospitals will use for classifying patients.
- Ken Cahill arrived for a week from June 26 through July 3 to participate in the discussions between the Ministry of Health, the National Municipal Association and the political and administrative leadership of the region/regions selected for hospital restructuring.
- BHRP COP attended on the June 21 the first meeting of a new working group that was organized by Dep. Prime minister and minister of economy Mrs. Shuleva. Task of the working group was to work on the preparation of the Public Health Code to eventually consolidate the various health care laws. The meeting was also attend by the minister of health, the chairman and director of the Health Insurance Fund, and the chairman of the parliamentary health commission. See Annex 1.
- Ibrahim Shehata was invited to attend a roundtable discussion organized by the Bulgarian Social Party to discuss health reforms in Bulgaria. The meeting was attended by many of the health policy decision makers.
- BHRP continued it's assistance to the VHI Association in Bulgaria – new company was accepted in the association.

Inpatient Care Financing

- The National Center for Public Health was recognized as a coordination center for the NTP on behalf of the MoH. BHRP COP met with Prof. Lubomir Ivanov (director of NCPH). The meeting was focused on the next decision makers meeting, which subject will be introducing and decision for purchasing the groupers software.

- Mrs. Jugna Shah arrived on June 6 for two weeks.

- The National Training Program (NTP) for the new scheme for hospital financing based on DRGs was open on the June 14. The program started with a "refreshment" course for trainers. The BHRP and Mrs. Jugna Shah were observing the module. International Experts from Georgetown University were Dr. Adam Kozierkewich and Dr. Jacek Gralinski. They discussed with Mrs. Shah the involvement of the external experts during the upcoming modules.

- BHRP and Mrs. Shah had meeting with Dr. Ivan Bukarev (director of the NHIF) and the case-mix office, located at the NHIF, to discuss the beginning of the NTP and the different modules and what should be the issues for discussion during the DMs meeting.

- Mrs. Shah and BHRP worked with the technical working team on preparation of the materials for the decision makers meeting, scheduled for June 15. Main subject of the meeting was introducing the different grouper software options. BHRP contacted American (HCFA) and Australian (AR DRG) grouper providers in order to get the latest information for the DM and recommendations for the best for Bulgaria options.

  BHRP prepared all materials for the meeting, presenting the international experience and different options for groupers selection for Bulgaria. All materials were sent to the DMs ahead of the meeting so they could get familiar with the information (see Annex 2).

  The meeting was attended by: deputy Minister of Finance and Chairman of the Board of the Directors of NHIF Kiril Ananiev, the new Director of the NHIF Dr. Ivan Bukarev, Dr. Andrei Kehayov – Chairman of the Physician Union, Prof. Lubomir Ivanov (director of NCPH), the Dep. director of NHIF Teodor Vasilev, Dr. Demirov – member of the Physician Union, and also members of the technical working team: Dr. Yavor Drenski – chairman of the group and the case-mix office, Jeni Nacheva – budget director of NHIF, Ibrahim Shehata – COP of the BHPR, Mrs. Jugna Shah- consultant to BHRP and Assia Toumbanova – BHRP Coordinator.

  All participants agreed that it is better not to make a decision upon purchasing any grouper because of two reasons: first, not everybody for the decision making group were there (Minister Bogoev and Dr. Sterev were not there) and second, it was proposed to go with evaluation of the three groupers that were recommended by the technical team as a best solution for Bulgaria. It was given the task to the technical group to proceed with the procedures for obtaining a research licenses for the groupers. Everybody agreed that it is a necessary step that should be done

as soon as possible in order to be able to run the date and start doing the budgets simulations. Date of the next meeting was proposed July 8.

- According to the decisions taken during the meeting BHRP and Mrs. Shah had meetings with Ass. Prof. Evgenia Delcheva and Ms. Albena Andreeva from the case-mix office to review the economic data received from the pilot hospitals and the approaches of making the budgeting simulations.

- Mrs. Shah and the COP of BHRP had meetings and with Dr. Bukarev and Mrs. Jeni Nacheva from the NHIF, Dep. minister Dr. Salchev and Prof. Ivanov (NCPH) after the DMs meeting to make sure that everyone are going in the same direction and to discuss the next steps of the f uture pilot implementation process of the DRGs in Bulgaria.

- Mrs. Shah met Dr. Kehayov to provide him with more detailed information on the specifics of making budgeting simulations being in the DRG base financing environment.

- BHRP attended the opening of the second training module on June 24.

- BHRP and Mr. Kenneth Cahill met with Dr. Shterev (chairman of the Parliamentary Health Commission) to update him on the decisions taken during the DM meeting and to make a short presentation on the given materials.

Hospital Restructuring

- Ibrahim Shehata had a meeting with Dr. Oleg Hinkov, the new deputy Minister of Health, to discuss some of the Stara Zagora findings as well as carrying possible future assessment of the inpatient care sector in the Razgrad region. Dr. Hinkov will discuss the issue further with the minister of health before returning back to the project. The meeting was attend by Drs. Lisiski and Manov from the health project and Ms. Dimitrova from USAID.

Annex 1

Health Insurance Code
DRAFT

Terms of Reference

A. Background

The Health Reform in Bulgaria has been under way for over 5 years now. Having introduced health insurance and having applied various organizational and managerial decisions, the time has come to conduct a comprehensive analysis and identify bottlenecks that hinder the further development of the reform.

The first steps for reforming the health sector were initiated in the early 90s reflecting the unwillingness of the society to continue implementing the older model characterized by:

- centralized command administration
- define rather than recognize health needs of the individuals as well as of the population
- centralized budget and extensive development of facilities
- holding patients "captive" within the health region by residence, i.e., the regional principal of health care provision
- low compensation and motivation of health professionals
- difficult access to health care services
- full responsibility of the state for the health status of individuals and the population, i.e., the paternalistic model without clear personal responsibility (the autonomous model)
- lack of efficient financial mechanisms reflecting both raising and spending of funds
- integrative model of the health system (state ownership)

Considering these expectations the period between 1995 and 2000 was dedicated to studying and simulating various models. As a result the modern health legislation was adopted, e.g.:

- Drugs and Pharmacies' Act, 1995 (amended 13 times so far)
  It determines the new public model to be used in the distribution of drugs, the terms and conditions for granting permission and control of manufacture, permission to use, clinical testing, consumption, import, export, wholesale, retail, quality assurance, efficacy and safety. As a result real market principles were introduced

- Health Insurance Act, 1998 (amended 14 times so far)

It stipulates the new model of health financing, the establishment of a single institution for collection and management of funds (NHIF) and management of health insurance relations between consumers (population) and providers (facilities)

- Health Care Institutions Act, 1999 (amended 7 times so far)
  It regulates the status of health care facilities, the organization of health services, the role and responsibilities of providers, their horizontal as well as vertical relations with the NHIF and other government entities and NGOs. The integrative model of state ownership is replaced by equal treatment and independence of providers, an opportunity for change of ownership (privatization) is given as well as equity of various forms of ownership of health care facilities

- Professional Physicians and Dentists Unions' Act, 1998 (not amended)
  It settles the structure, organization and activity of professional organizations of physicians and dentists as well as their responsibility in the event of violation of professional ethics.

- Control over Narcotic Drugs and Precursors Act, 1999 (amended 5 times so far)
  It provides for the organization, powers and obligations of government bodies that exercise control over manufacture, processing, trade, consumption, storage, import, export, transit, carriage, transportation and reporting of narcotic drugs and precursors; the measures against abuse and illegal trafficking, research and expertise related to narcotic drugs and precursor.

- Blood, Blood Donation and Blood Transfusion Act, 2003
  It regulates donation, taking, diagnostics, processing, transportation, storage, use of blood and blood ingredients, quality assurance and safety

- Organs, Tissues and Cells Transplantation Act, 2003
  It stipulates the terms and conditions for transplanting organs, tissues and cells in human medicine.

The Public Health Act (1973) still remains valid. It regulates activities relates to health protection and aims at assisting the creation of favorable conditions for physical and spiritual development of the population, prolonged active lives and improved reproduction. Despite its numerous amendments (28), it was designed for other type of social relations (referred to above) that do not comply with up to date requirements of the community and the desire for a reform. Thus the Health Act came into being and it is currently has a second reading in Parliament. This law will regulate social relations associated with health protection while Chapter 3, Health Care provides only an overview of some elements of health care provision, access and quality, patients' rights, emergency care, natural disasters and crises as well as expertise, however, it does not include any reference to the components and concepts related to health care benefit packages, insurance levels, responsibilities of institutions, e.g., government agencies, NHIF, NGOs, etc.

Despite the numerous positive changes and advantages in the development of the health sector in the last couple of years, the health reform has failed to meet public expectations, on the one hand, and provide opportunities for the state to actually exert an impact on health care and make real managerial decisions. Various sociological surveys conducted in the course of the reform have indicated that the population is generally dissatisfied with the overall situation with health insurance and the delivery of adequate health care services that correspond to actual needs. There is also the discontent of health professionals who failed to reach the desired level of compensation and do not feel sufficiently motivated to participate in reform processes. Unfortunately, it should be accounted for the fact that the reform was promoted by health care specialists who often put their personal interests before public good.

All this is indicative of the need to analyze achievements and identify specific steps that correspond to public expectations. The multiple legal amendments to the health legislation (often lacking any coordination) not only fail to resolve but tend to aggravate outstanding problems and speak for an absence of a vision about the future of health insurance and the health system in general.

The Bulgarian government has seen this as a major concern for the last two years, especially since the health priority of the nation has been considered state priority. The Government is currently supporting several initiatives of the MoH along with the NHIF for implementing a set of key structural reforms in various aspects of the health system.

This sets the context for drafting a Terms of Reference that aims to develop a Health Insurance Code which will assist the Bulgarian government in finalizing the basic steps associated with the continuation of the health reform. The outcome of these efforts will guarantee the country's further progress and compliance with specific requirements that the Government and international credit institutions would consider crucial in view of the successful implementation of the health reform.

Drawing on international experience and complying with the guarantee policy of the state in terms of health care, the Government has recognized the significance of the potential social impact of the proposed reforms, their monitoring and facilitation. Therefore, the ToR has been based on STEP analysis (social, technological, economic and political analysis) that covers political, health demographic, legal and financial assessment that go deep into the very core of the health reform in order to explore the possibility to develop a strategy for new social relations in the field of health insurance which will facilitate their codification in a future Health Insurance Code. On the basis of SWOT analysis it can be assumed special attention is to be paid on identifying possible measures for eliminating or limiting the negative impact of the reform on the most important stakeholders: MoH, NHIF and health insureds. Analysis should focus on the influence of external factors, both positive and negative, in the implementation of different approaches to system changes as well as the possibility of the institutions involved to have their impact.

The initial overview of the program for reform has identified one aspect that requires a fundamental analysis of what has been accomplished so far and the long-term perspectives of the health reform. This will throw light on critical social issues which should be studied in advance so that an effective mechanism for monitoring the health reform progress be elaborated.

B. Health Insurance System Current Status

Health care expenditures have been marking a stable increase in the last 3 years. The health sector has been granted the major budgetary priority for 2004. Health care spending for 2004 was estimated as BGN 1,632.8 million (4.27% of GDP), the trend is that their relative share will increase to 4.5% of GDP or more depending on current budget year so that their reach the level of EU countries.

NHIF reimbursements constitute the major portion of health care spending. Currently, outpatient care is primarily funded through the NHIF budget. The latter plans to provide guaranteed access to outpatient care services. Within the breakdown of expenditures, inpatient care accounts for the largest portion.

Performance based hospital payment provided through the NHIF budget is directed to the discipline with the highest resource consumption, i.e., surgery. It boasts the highest utilization rate and has the highest social significance while accumulating hospitals' largest financial deficit. The number of diagnoses covered by CCPs in the 2004 NFC reached 1,950, the focus being on most frequent diseases nationwide (cardiovascular, oncological, respiratory, nerve system, trauma) and on diseases that lead to long-term incapacity for work or permanent disability. The health issues of priority groups like children and pregnant women have also been considered. The basic principal applied in the selection and reimbursement of CCPs by the NHIF has been the provision of an optimal number of services to the largest possible groups of patients.

The plan is that the NHIF will fund an increasing number of CCPs (or DRGs) so that in 2006 or 2007 hospitals will be paid entirely through the NHIF budget.

The allocations to health care reimbursements sets the frame for negotiation and, therefore, determines the volume of services that can be provided to health insureds.
A deficit in the NHIF budget was planned for 2004 and after, even in the event of a possible increase of the contribution rate. The resolution of this issue will be sought in the future, one option being the introduction of an official co-payment along with protective schemes for the socially disadvantaged.

The strategic analysis of the current stage of the health reform has outlined substantial problems. Most of them have been the subject of continuous debate and well grounded criticism:

- absence of synchronization of new legislation which has negative consequences for drafting the NHIF budget, the execution of the NHIF Budget Act and the annual negotiation of the new NFC
- lack of clarity regarding coverage of health risks, i.e., what is covered by the state and what by individuals
- lack of clarity in the relations between various players: the state, health insureds, payers (NHIF, VHICs, general/life insurance companies)and providers (facilities and professional organizations)
- vague distinction between the concepts of health prevention and health promotion, and the typical health care activities; this creates problems with defining benefit packages and the calculation of premiums
- unclear parameters of the benefit packages (basic, minimal, additional, optional, etc.) and risk estimates
- absence of sufficient and credible information about the actual health needs which impedes planning of resources
- difficult access to health care and quality of care that fails to meet requirements and expectations
- prevalence of financial restrictions over the social and health goals of the insurance system
- shortage of funds that would enable wider access of insureds to specialized care and diagnostic testing
- performance based payment under CCPs (NHIF) or case based payment (MoH) that covers only part of the actual cost of the services provided
- difficult costing of unit of service due to problems with defining and diversification of services; merging of demand and supply because of poor awareness of patients, supply of health care services by monopoly facilities, availability of public goods with indivisible effect and such with external effects, imperfect competition, strict integration of health care services – vertical and horizontal, desire to restrict financial risk for patients in market environment (the principle of solidarity) in order to avoid risk selection
- delayed development of an integrated information system in the health sector at large and in the NHIF, in particular as well as the absence of standards for medical information
- absence of a real system of NHA that identifies overall health expenditures (direct and indirect)
- difficulties associated with the entry and procession of clinical and cost data due to problems with electronic reporting which makes it hard to assess actual health needs
- increasing negative trend in the health and demographic status of the population.

The future development of the health insurance system should focus on maximum utilization of compulsory health insurance potential by preserving solidarity and promoting voluntary health insurance as an additional source of funding. Options for introducing compulsory (supplementary) voluntary health insurance might be considered as well. This could be possible only through clear regulation and stabilization of the level of payment through compulsory health insurance and state-funded health care. Solutions

should be sought in terms of defining the scope of coverage (basic benefit package), co-payment, various forms of penalties, etc.

The new codification of health insurance should ensure the execution of the following tasks as well:

- collection of health insurance contributions, monitoring their regularity and projecting their level
- collection, summary and analysis of information from various institutions (incl NSSI, NSI, Ministry of Labor, Tax Directorate) in order to make the correct management decisions and transparency of their activities
- improve information for providers and insureds, tracking and ELIMINATING the reasons for slow information flows, disclosing data on corruption or shady processes which is the fundamental significance for the successful implementation of the health reform
- comparative analysis of the data base required for the purposes of projecting, drafting and reporting the NHIF budget, unification of standards and methods for data processing
- enabling each provider/pharmacy to access certain volume of the data base, and each insured to his or her personal information within the NHIF information system
- decision making at all levels and management of cash flows and clinical data sets
- capacity building through training, technical assistance and practical expertise
- informing the public and counterparts on the rights, responsibilities, obligations and methods of using the health insurance system

This will enable the finalization and financial sustainability of the health reform and will guarantee its successful implementation.

C. Objectives

The new codification of health insurance and the drafting of the Health Insurance Code will regulate the social relations associated with compulsory health insurance, VHI, social health protection for the uninsured. It will preserve all positive elements of the currently applied principles of equity and guaranteed access to a minimum benefit package for the Bulgarian population while all elements that do not correspond to actual needs.

Health insurance is an activity of collection of health insurance contributions and health insurance premiums, management of the funds collected and spending them on health care services and medical products required for recovery, protection and strengthening of the health status of compulsory and voluntary health insured persons.

Social health protection (social health assistance) as a supplement will be regulated as a system for state provision of health care services, drugs and supplies within a minimum benefit package that is designed to meet the basic health needs of those individuals who

are unable to pay their health insurance contributions. The needs of individuals or risk groups should be assessed separately.

Analyses and preconditions for achieving the goals

- analyze external factors that have impact on the system, the system status, the legislation and discrepancies identified in it
- analyze existing programs for improving the health status of the population and efficient spending of funds allocated to health care
- analyze of the health status of the population: morbidity, mortality, disability – permanent and temporary
- improve access and quality of outpatient and inpatient care through improving payment schemes, analysis of the current economic and medical statistics in order to make more stable financial and statistic findings
- implement more efficient, fair and transparent drug policy directed to satisfying the need for drugs prescribed for home care while avoiding unnecessary and unjustified expenditures
- create, develop and improve an integrated information system capable of generating a unified data base
- optimize the planning of macroeconomic resources by s[reading the burden of payment among the state, VHICs and the population
- optimize collection of NHIF's revenues and their efficient allocation
- improve efficiency and direct results from the audit of the type, volume and quality of the health and dental care services agreed, pharmacies as well as the legal conformity of purchasing services and products and incurring administrative costs
- assess current and planned revenues and expenditures for a 3 to 5 year period, considering both macroeconomic and health sector projections and their impact of the NHIF's financial sustainability
- analyze health, demographic, legal and financial situation based on previous evaluations and social analyses conducted by the Bulgarian government and International institutions and produce a detailed Assessment Report and a Strategic Plan for monitoring the impact of health strategies on the population and on the financial sustainability

D. Scope of work

1. The medium and long-term projections of spending are based on the frame set by the NFC (basic benefit package, co-financing, etc.) and on a number of realistic hypotheses. The assumptions regarding the revenues should recognize the changes in the growth of GDP, the purchasing power, unemployment, various options for premium payment, while those regarding expenditures should consider the overall and sector specific inflation rate, the anticipated changes in human and physical perspectives, the health sector market of labor, definitions and costs of the basic benefit package, VHI scope and possible market, age of the population and, hence, mobility and mortality. Revenue projections should account for the

dynamics in the labor market (higher mobility, flexitime, etc.), simulation of the impact of different prices and revenue estimates, comprehensive analysis of the weight of most frequently observed situations

2. The assessment should also include different scenarios for restructuring, e.g., financial assumptions regarding one (or several) payers/insurers, reduced administrative costs, recruitment of staff, etc., the role of monopsonic and strategic purchasing using comprehensive and well defined contracts, eliminating differences between public and private health care providers, introducing family medicine with clearly defined rules, methods for payment different providers, etc.
3. Using the above scenarios, the assessment should focus on the analysis and forecast of government subsidies from the consolidated budget for the same time frame and specific legal provisions for the relevant sector
4. Based on above analyses and comparative figures from experienced countries (Germany, Holland, France, etc.) and relatively new health insurance systems (Poland, Slovenia, Croatia, etc.), assess the scope of the basic benefit package, projected expenditures, premiums, subsidies, acceptability, co-payment and applicability prior to making recommendations about the universal and additional health insurance
5. Present and discuss the key findings and recommendations at seminar (NHIF, MoH, MoF, Medical Colleges, Teaching hospitals, health care facilities, Parliamentary health commission, Physicians Union, NGOs, etc.).

E. Tasks (ToR)

The following tasks are to be accomplished by the team of experts in the timeline specified:

a. Identify the subject matter

The team of experts will receive adequate Terms of Reference and understanding of the key processes and practices that govern the health sector in Bulgaria, the role and responsibilities of counterparts. Through reviewing available literature and conducting a series of interviews, the team will define the current state of affairs regarding financing and legislation, and will study the possible impact of various scenarios on the sector development.

b. Develop the design of the Health Insurance Code

1. Convene inter-institutional commission supervised by a representative of the Deputy PM and Minister of Economy, Mrs. Lidia Shouleva. It should include representatives of the MoH, NHIF, Ministry of Labor, NSSI, Ministry of Education.

Experts will complete the following tasks:

- identify key players

- achieve the goals of key counterparts, assess their role, capacity and training needs
- analyze the legal framework and its reflection of the administration of procedures associated with the health reform; analyze the interrelation between the existing legislation and the institutional agreements in this field
- study the widely recognized financial schemes and procedures as well as those that already exist in the system
- analyze available methods for control and evaluation; make recommendations based on the possibilities for institutional development, and
- enable supervision of progress by the MoF and the MoH.

2. Establish 3 Working Groups

- **WG 1** will assess the current state of the health and demographic environment: actual health needs and financial frame of the health sector – **2 months**
- **WG 2** will be responsible for the legal analysis of the legislation – **2 months**
- **WG 3** will summarize findings and recommendations and will draft a Health Insurance Code by the beginning of October 2004.

d. Develop a detailed progress report and action plan

Report Structure:

- Introduction. Brief presentation of conclusions and recommendations
- Political, legal and administrative framework. Study European practice and EU Directives.
- Description of financial and health issues. Summarized description of the main task in the financial, social and political context.
- Action plan. Description of facilitation, observation and institutional measures undertaken in order to eliminate unfavorable financial implications. The plan should also contain the necessary procedures for achieving the goals. The SA Group will (1) identify responsibilities in the event of unfavorable consequences, (2) define the conditions for their timely and efficient elimination and (3) describe the significance of those recommendations. The plan should have the following components: monitoring, possibility for development and training, integration of the plan within the health reform scheme, execution of the program and financial estimates.

Once the first two WGs have delivered their reports, a public debate of their conclusions should be initiated in the form of a round table discussion between all counterparts – government agencies, professional organizations, trade unions, NGOs.

Draft Structure of the Health Insurance Code

COMPULSORY HEALTH INSURANCE
GENERAL PROVISIONS
Scope

Principles
Insured persons
Insurers
Insurance rights
FINANCIAL STRUCTURE
Insuring institutions
Budget
Revenues
Expenditures
Short-term interest free loans
Investment
Banking
Budget execution
Annual report
GOVERNANCE
Role of government agencies
Management bodies
INSURING VARIOUS CATEGORIES
Benefit packages
Eligibility
Define insurance burden
Handling more than one insurance contribution
Categories of insured persons
Prescriptive limitation
Regulatory framework
RIGHTS OF INSURED PERSONS
CONTROL
Controlling bodies
Rights of controlling bodies
Prohibition of other activities
Penalties
Interest
Returning unreasonably received amounts
Prescriptive limitation
Deferred liabilities
DISPUTE
Grievances
SUPPLEMENTARY AND VOLUNTARY HEALTH INSURANCE
SOCIAL HEALTH PROTECTION – organs, types of activities and services
VHICs' INCORPORATION, LICENSURE AND MANAGEMENT
General provisions
Offering supplementary social insurance
Regulation and control
INSURANCE CONTRIBUTIONS
Type and rate
Payment

Collection
RIGHTS OF THE INSURED PERSONS
Limitations
Relieve from responsibility for payment
Type of insurance
REPORTING AND ACCOUNTING
Requirements
Monthly reports
Annual financial reports
Management report
Publishing the report
Obligation for submission
RESERVES
Guarantees for meeting liabilities
VHICs' reserves
LIABILITY IN THE EVENT OF VIOLATIONS
Grounds
Identification of violations
CONTRACTS
Conclude a health insurance contract
Content

F. Qualification of Working Groups experts

Lawyers, physicians, finance experts

- degree and professional experience in an area related to health care
- proved on the job experience in a executive, supervisory or managerial position
- strategy building skills with a global vision on problems associated with health care
- experience with statistic methods and their utilization in estimating expenditures

IT experts

- Training in IT, 5 years professional experience in the field
- Teaching and presentation skills. Organizational skills.
- Ability to analyze technical data, statistic methods, tools, etc.

Institutional Agreement

Experts will be appointed by the MoH and the NHIF, will report to the Minister of Health and the Director of the NHIF. They will collaborate with other institutions (Ministry of Labor, NSSI)

Materials

- Implementation plan

- Organization of public event for reporting progress and achievements
- Assessment of current policies

G. Observers

Control will be executed by authorized representatives of respective institutions reporting to Mrs. Shouleva and Minister Bogoev supported by advisers. All materials will be reviewed and approved by an Inter-institutional Commission.

H. Timeline and necessary steps

a. Determine the composition of the Inter-institutional Commission and release an order by Minister Bogoev – by end of May
b. Determine the composition of the Working Groups and distribution of specific tasks – order by Minister Bogoev – by end of May
c. First reports by WG 1 and WG 2, arrange a working meeting of the Inter-institutional Commission – by end of June
d. First Draft of the Health Insurance Code by WG 3 – by August 20
e. Working meeting of the Inter-institutional Commission and decision making – around August 25
f. Roundtable or conference entitled Health Insurance. Accomplishments and Perspectives. Organized by the Inter-institutional Commission, under the auspices of the Minister of Health – beginning of September
g. Submit the proposed draft to the Council of Ministers – end of the September

Annex 2

Meeting of the DRG Decision-Making and Technical Working Group
Tuesday, June 15, 2004

Agenda for Discussion

1. Update on the DRG Implementation Roadmap

2. Review and Discussion of the Technical Working Group's presented materials in order for Selection of a Grouper to Classify Clinical Patient Data into DRG groups

    a. Review of the evaluation conducted to date and the international literature

    b. Open Discussion

3. Required Decisions to Move Forward with the Pilot Implementation of DRG-based Financing in Pilot Bulgarian Hospitals on January 1, 2005

    a. Selection of the grouper; short term (for 2005) vs. long term

    b. Selection of the relative values in order to develop prices

    c. Selection of hospitals – basis and number

    d. Estimation of the 2004 budget to serve as a basis for the 2005 hospital budgets based on DRGs

Executive Summary for Grouper Options

What is a grouper?

A grouper is a piece of software used to aggregate discharged patients from the acute care hospital setting into discrete groups based on diagnosis and procedure codes that are intended to be clinically similar and in terms of resource use. This aggregation, also called grouping, relies on both the clinical information (diagnosis and procedure codes) and the demographic information such as age, sex, etc. The diagnoses and procedure codes are aggregated into groups called Diagnostic Related Groups (DRGs). By having a finite number of groups, rather than thousands of diagnosis and procedure code combinations, we can easily quantify the overall volume and types of services provided in hospitals. Each DRG has an associated relative weight, which represents the relative costliness of one group compared to the others. Therefore, selecting a grouper inherently means selecting a set of relative weights, which are then used to generate prices. If a country decides to borrow relative weights from another country in the early years of case-mix financing, then the selection of the grouper becomes even more important. You'll want to understand what relative weights are included in the grouper and review the cost factors that went into creating those weights. Once you have the groups and the weights, you can calculate the hospital's case-mix index, and then begin creating hospital budgets using a case-based financing system approach.

Who needs a grouper? Why?

The grouper software will be useful at different levels, by different users, and for different reasons. The primary uses are for financing, hospital management, clinical analysis, and quality assurance activities. Aggregating the clinical data into similar groups and comparing the outcomes/production within and across hospitals, departments, and physicians can provide all levels of users with important information. Remember that the grouper is a key building block to implementing a financing system, as it is the tool that allows aggregation of patients into finite groups that we assign prices/payment rates to. The relative weights and the volume are key elements in creating the budgets used for financing.

- *Centrally*
  - *The NHIF will need a grouper to aggregate the clinical patient data in order to calculate case-mix (a combination of the volume and types of patients). This grouped data can be used for clinical and financial analysis, budget modeling, and the development of an overall payment system based on DRGs.*
  - *The MoH may also want a grouper or alternatively they can request grouped data from the NHIF if they are interested in doing some specific analyses.*
  - *An "Audit Commission"[1] or a "Quality Monitoring Board" will either need a grouper of their own or they will need to have access to grouped data so they can prepare analysis to uncover true coding errors vs. fraudulent coding situations.*

- *District/Region or Local Level*
  - *The district health authority or the district representative of the health insurance fund may also want to group the data for the hospitals in their region if the*

[1] An Audit Commission should work closely with the NHIF and/or the MoH, the MoF, and other government entities to monitor the incorrect coding or reporting of data from the hospitals. In cases where hospitals report incorrect information fraudulently, the Audit Commission should implement fines or penalties. The specific mission, organizational chart, and functions of such a Commission should be developed later.

hospitals are required to report the patients to them. This depends on the local situation and requirements.

- *Hospital Level*
  - *Most hospitals will want a grouper once they are being financed according to DRGs. They should want to group their data internally and not simply rely on the central level's grouping results. This may not be in the case in Bulgaria, but it is very likely.*

What things should be considered in selecting a grouper?

- *What do Bulgarian decision-makers want to achieve with the implementation of DRGs?*
- *What resources are available?*
  - *Time (to make own grouper, to evaluate others, etc.)*
  - *Money (to purchase the grouper software vs. the specification; to maintain it if we make it Bulgarian, how many will be purchased etc.)*
  - *How much does the grouper cost for one copy vs. multiple copies? Is there a discount if multiple groupers are purchased?*
- *For political reasons, does the grouper need to be Bulgarian, or can it be foreign?*
- *If the grouper is purchased from abroad, does it matter from where?*
- *Does the grouper need to be consistent with what other countries are using?*
- *Will the selected product be compatible with existing coding systems?*
- *Will the product be easy to use and interface to other products?*
- *Will customer service be included if a commercial grouper is licensed?*
- *What level of accuracy is required for:*
  - *The groupings – do the categories reflect Bulgarian medical practice?*
  - *The relative weights – do they reflect the resource consumption of a similar set of services; do you need to have relative weights that reflect your experience (i.e., inclusion of capital, salaries, etc.)*

BULGARIA HEALTH REFORM PROJECT

Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810

JULY & AUGUST 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

Prepared by:

BearingPoint, Inc.
74-A Bouzloudja St.
Sofia, Bulgaria

USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 13
July & August, 2004

Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
Contract Number:	PCE-I-00-00-00014-00
Task Order:	810
Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

General

- Due to the fact the COP was on vacation between August 9-19 and many of the project's counterparts use the month of August for summer holidays, we have combined the July and August monthly reports into one.
- The DRG National Training Program, Second module continued June through August:
  - Training Course - Training of Trainers - experts from MoH (RHC), NHIF (RHIF), PU, NII and NSI: Training in Coding (morbidity and mortality) and Hospital Management and Accounting
  - Training Course - Hospital Managers and Accountants: Hospital Management and Accounting
- Mrs. Jugna Shah arrived for one and a half week on July 5 through July 14 to assist in the next decision makers meeting to introduce options for developing budgeting simulations. She was also expected to meet with the counterparts in order to insure the consensus among all institutions on the DRG based mechanism for hospital financing.

Inpatient Care Financing

- Mrs. Jugna Shah arrived on July 5 through July 14.
- The Second module of the National Training Program (NTP) on hospital financing based on DRGs was open on June 24. The module was in two parts. The first part was for two weeks for experts from MOH (RHC), NHIF (RHIF), PU, NII and NSI. In the first week they were trained in coding mortality and morbidity and in the second - on the basics of Hospital Management and Accounting. The second part of the module was developed for hospital managers and hospital accountants from all Bulgarian hospitals. It was opened on July 12 for four weeks. The BHRP and Mrs. Jugna Shah were observing the module. Mrs Shah facilitated a discussion during the second day after the opening. Dr. Adam Kozierkewich, international expert from Georgetown University, was also attending.

- BHRP and Mrs. Shah had a meeting with Dr. Ivan Bukarev (Director of the NHIF) and the case-mix office, located at the NHIF, to discuss the contents of the next DMs meeting.
- Mrs. Shah and BHRP worked with the technical working team to prepare the materials for the decision makers meeting, scheduled for July 8. The purpose of the meeting was two-fold; first to have a short presentation on how to create budget simulations for the pilot hospitals that would be financed in 2005 using DRGs and second to discuss exactly who would be the financing agency (i.e., the MOH or the NHIF) and how this would be done in terms of the money available. (See Annex 1)

  The meeting was attended by: Dr. Atanas Sterev - Chairman of the Parliamentary Health Commission, Mr. Kiril Ananiev - Deputy Minister of Finance and Chairman of the Board of the Directors of NHIF, Dr. Petko Salchev – Deputy Minister of Health, Dr. Ivan Bukarev - Director of the NHIF, Dr. Andrei Kehayov – Chairman of the Physician Union, Prof. Lubomir Ivanov - Director of NCPH, Dr. Valeri Tsekov – member of the Parliamentary Health Commission, Katia Parakozova– expert from MoF, Dr. Demirov – member of the Physician Union, Jeni Nacheva – budget director of NHIF, Dr. Yavor Drenski – Chairman of the group and the case-mix office, Dr. Mihaela Mihailova – PMU World Bank, Mrs. Rayna Dimitrova – USAID, Ibrahim Shehata – COP of the BHPR, Mrs. Jugna Shah- consultant to BHRP and Assia Toumbanova – BHRP Coordinator.

Short Summary of the Discussion

The meeting was opened by Dr. Bukarev who explained the purpose and the overall agenda of the meeting. He then turned the meeting over to Mrs. Jugna Shah who gave a short presentation focused on the key aspects of the budget simulations for the pilot hospitals. This was necessary since all participants did not have the same level of understanding on what it takes to simulate the budgets. In addition, there were many options on how to create the budgets especially when thinking strategically about the longer term and successful implementation of DRGs. There were several technical decisions that decision-makers must make so that budgets could be appropriately simulated by the NHIF's case-mix office. Several very good and practical questions were asked by both Dr. Sterev and Mr. Ananiev on the calculations, formulas, and how the data quality could be monitored so that hospitals would not try to "cheat" the system. These questions were answered.

Dr. Bukarev outlined the key questions from a strategic/political point of view that must be addressed immediately. These are listed below:

1. Who will do the financing of the pilot hospitals (i.e., the MOH or the NHIF)?
2. Will the entire activity of these hospitals be financed using only one source of funds and one method?
3. Will the MOF be able to allocate separate money in 2005 for DRG financing of the selected pilot hospitals?
4. What will be the legislative basis for the implementation of the DRG pilot financing mechanism (i.e., the Framework Contract, modifications to the Health insurance Act or the creation of a new law, Ministerial ordinance, or some other mechanism)?

The group seemed to agree that these were very important, and even more important than the technical issues related to simulating budgets. Jugna Shah tried to explain that both are critical and that decision-

makers and the technical team at the case-mix office must work on both simultaneously given the short time frame in which implementation must occur.

Preliminary Decisions/Issues Raised

1. The MOH should do the financing for the pilot hospitals in 2005 since it will be easier than going through the Framework Contract or modifying existing laws. The group agreed with this in principal, but a discussion with the Minister of Health immediately before the final decision is needed.

2. The current legislative base need to be reviewed to make sure that patients who contribute money through their taxes to the NHIF could still be "financed" by the MOH for their care during the DRG pilot financing system implementation in 2005.

3. The case-mix office of the NHIF will continue all of the technical functions required to support the new DRG pilot financing system even in the event that actual reimbursement for the pilot hospitals is made by MOH, as they are the most knowledgeable and equipped in terms of staff and resources to do this work. The MoH and the NHIF should sign a contract to that effect.

4. Both the 3M IR-DRG grouper and the Australian Refined DRG grouper will be evaluated prior to making the final selection of a grouper.

5. The National Training Program should continue.

6. Budget simulations should reflect the needs and concerns expressed by the decision-makers to have a smooth, irreversible implementation that creates some risk and opportunity for the hospital in terms of losing and gaining money. This will create an incentive to increase efficiency. This means that the preliminary budget simulations should include blending of base rates (hospital rate with the peer group rate) and the use of a risk corridor. *These concepts in terms of the definitions and formulas were provided in the presentation.*

Next Steps/Action Items

1. Dr. Sterev will discuss the issues raised on the decision-makers meeting on July 8, 2004 and the immediate decisions that need to be taken by the MoH with Minister Bogoev in order to have the DRG pilot financing implementation process begin on January 1, 2005.

2. The NHIF agree to review the current legislative base to make sure that patients who contribute money through their taxes to the NHIF could still be "financed" by the MOH during the DRG pilot financing system implementation in 2005.

3. The NHIF will complete the review of the grouper licensing agreements and obtain them as soon as possible. Budgets will be simulated once the groupers are received and will be compared to the budget simulations prepared by the 3M/WB project.

- BHRP and Mrs Shah developed the minutes of the meeting and sent them to all parties attended the meeting.
- Mrs. Shah met with Dr. Kehayov and experts from the Physician Union to provide them with more detailed information on the specifics of making budgeting simulations.

Hospital Restructuring

- Dr.Petko Salchev, Deputy Minister of Health, visited Lovech, Gabrovo and Stara Zagora to discuss the USAID BHRP assessment reports. He met with representatives of the local authorities, the directors and doctors at the hospitals. Following a fairly heated discussion a decision was taken to form a local working group in each region to develop proposals for hospital restructuring based on the actual local understanding of the problems. The proposed recommendations would then be compared and reconciled with the recommendations made by the BHRP. A follow up meetings with participation from the BHRP was scheduled for November.

ANNEX 1

Meeting of the DRG Decision-Making Group
July 8, 2004

NHIF, 1 Krichim street

Agenda

1. **Opening of the Meeting – Dr. Ivan Bukarev**
2. **Presentation on Simulating Hospital Budgets Under Case–based Financing for DRG National Implementation – Mrs. Jugna Shah**
3. **Issues that Require Practical Decision-Making to Implement the Pilot Case-Based Financing System, Starting January 1, 2005 – Dr. Ivan Bukarev**
4. **Open Discussion**
5. **Review on the DRG Implementation Roadmap – Dr. Ivan Bukarev and Dr. Yavor Drenski**
   - **Update on the progress made with the National Training Program**
   - **Update on grouper selection and licensing agreements**

Summary of the Discussion

The purpose of the meeting was two-fold; first to have a short presentation on how to create budget simulations for the pilot hospitals that will be financed in 2005 using DRGs and second to discuss exactly who will be the financing agency (i.e., the MOH or the NHIF) and how this will be done in terms of the money available. While these two discussions are different since one is technical and the other more strategic/political, the common link is that decision-makers must understand the issues related to both in order to make decisions about the DRG pilot financing for 2005.

The meeting was opened by Dr. Bukarev who explained the purpose and the overall agenda of the meeting. He then turned the meeting over to Jugna Shah who gave a short presentation on the key aspects of budget simulations. Several very good and practical questions were asked by both Dr. Shterve and Mr. Aninanv on the calculations, formulas, and the how the data quality could be monitored so that hospitals do not try to "cheat" the system. These questions were answered.

Because Mr. Aninanv had to leave early, the group agreed to skip to the end of the presentation so that Dr. Bukarev could outline the key questions from a strategic/political point of view that must be addressed immediately. These are listed below:

1. Who will do the financing of these hospitals (i.e., the MOH or the NHIF)
2. Will the entire activity of these hospitals we financed using only one source of funds and one method?
3. Will the MOF be able to allocate separate money in 2005 for DRG financing of the selected pilot hospitals?
4. What will be the legislative/legal basis for the implementation of the DRG pilot financing mechanism (i.e., the Framework Contract, modifications to the Health insurance law or the creation of a new law, Ministerial ordinance, or some other mechanism)?

The group seemed to agree that these were very important, and even more important than the technical issues related to simulating budgets. Jugna Shah tried to explain that both are critical and that decision-makers and the technical team at the case-mix office must do both simultaneously given the short time frame in which implementation must occur.

There was some discussion and concern that things are not moving quickly and that we are always "discussing" without taking concrete decisions. Unfortunately, several members of the decision-making group had to leave early, which resulted in others expressing their feelings that things are not happening in a way that they should because people are not focused or dedicated in giving the time necessary to take important decisions if the pilot financing implementation is going to begin next year.

Instead of going back to the presentation in order to continue it and move forward, members of the group began raising a number of related and unrelated issues. This discussion continued for some time without a concrete basis of where it was going or what results would be achieved. Some questions were asked about how the implementation can be done in a way to protect the hospitals while also making it clear that things have begun in a good way so that with the elections next year, the DRGs are not reversed or eliminated. This is a very important question and one that requires serious thinking and consideration as there are many ways to begin the pilot implementation. Understanding the political environment and the potential threats to the system will help make some of the decisions regarding how the budgets are simulated. The group got back on track and began making some concrete statements and what appeared to be preliminary decisions.

Decisions about the overall money to distribute, creating peer groups of hospitals, calculating one set of relative weights, the case-mix index, and a set of DRG prices is necessary in order to prepare the final output which all participants desire – the actual budgets for the pilot hospitals for 2005. By the end of the meeting, based on the discussion the technical believes that the following budget simulations should be created to meet some of the needs and concerns raised by the decision-makers.

BULGARIA HEALTH REFORM PROJECT

Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810

SEPTEMBER 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

Prepared by:

BearingPoint, Inc.
74-A Bouzloudja St.
Sofia, Bulgaria

USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 14
September, 2004

Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
Contract Number:	PCE-I-00-00-00014-00
Task Order:	810
Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

General

- The third module of the DRG National Training Program started in the beginning of September with Training Courses – 1) training of hospital staff from all hospitals in coding and 2) training of the head nurses form all hospitals in coding.
- Mrs. Jugna Shah arrived for one and a half week on September 13 through September 22. Her SOW for this trip was to assist the NHIF with the data that they would receive under the World Bank's project and to meet with NHIF experts and MoF to work with them on some of the possible budgeting scenarios. During her stay Ms. Shah also met with senior officials from the NHIF, MOH, MOF and the Parliamentary Health Commission.
- The COP of the BHRP developed training on National Health Accounts in Bulgaria for experts from the MoH. The training was conducted in the period September 28 through October 1 in Bansko.
- MOH and BHRP had officially launched the fourth Hospital Assessment in the region of Razgrad on 10 September.
- Minister of Health reiterated in public his desire for introducing some form of patient co-payment for some CCPs in 2005 and for all CCPs in 2006 in order to curb unneeded hospitalization and to cease under-the-table payments in the hospitals. Dr.Shterev, Chairman of the Parliamentary Health Commission, supported the idea.

Inpatient Care Financing

- The Third module of the National Training Program (NTP) on hospital financing based on DRGs started from the beginning of September. This module is the last and the most extended/shifted in the time schedule, because of the importance to have very well train coders and because of the large number of people to be trained. The module was in two courses going in parallel. The first one was to train hospital staff from all Bulgarian hospitals in coding; and the second one, was to train hospital head nurses in coding.
  The training will end in the first week of December and that will close the training circle in this first and most important stage.

- Ibrahim Shehata met with Mrs. Jeni Nacheva (Director Budgeting in the NHIF) to discuss over a conference call with Mrs. Shah her meetings during her trip to Bulgaria.
- Mrs. Jugna Shah arrived for one and a half week on September 13.
- BHRP and Mrs. Shah had a meeting with Dr. Ivan Bukarev (Director of the NHIF) to discuss the follow-up steps after the end of the World bank/3M pilot hospital project. Dr. Bukarev suggested having a meeting with Mr. Ananiev, NHIF chairman and Deputy Minister of Finance, to discuss what to expect from the next year state budget in order to have a clearer vision of the financing in the healthcare sector.
- Mr. Ananiev, Dr. Bukarev met with Mrs. Shah and the project's COP. After a successful discussion about the details of the budgeting and who would be the most successful financing agent in the environment of implementation of the DRGs in Bulgaria, Mr. Ananiev stated that it was not realistic to expect to move with national implementation in January 2005, but it is doable, from a political point of view, for a number of hospitals out of the pilot project. He also stated that it would likely require the common will and efforts from members of the parliamentary health commission to bring that idea to an end, because Bulgaria had already build the technical capacity and had a well going national training program. Shehata and Shah promised to meet with Dr. Shterev, Chairman of the Parliamentary Health Commission, and to deliver the outcomes from that discussion. All attendants in the meeting agreed to do the same in higher-level meetings.
- The project's COP and Mrs. Shah met with Dr. Shterev (Chairman of the Parliamentary Health Commission) to update him on the discussion with Mr. Ananiev and Dr. Bukarev and to understand what his vision of the future of the DRGs implementation in Bulgaria was. Dr. Shterev also agreed that the implementation process should not stop and promised to present the idea of having DRGs as a hospital financing mechanism in a very simple way in front of the Political council of the ruling party. He asked Mrs. Shah and the BHRP to help with the preparation of the presentation. Dr. Shterev wanted better to understand the budgeting part himself so to be ready to present it in front of economists. He highly appreciated the BHRP assistance.
- Shah and Shehata met with the case-mix office to review some of the results that arrived from the 3M company and to discuss the future steps according to the budgeting based on their presentation. The 3M company, as an executer of the World bank DRGs pilot project that came to an end, has to present their final report in front the political officials.
- Mrs. Shah departed Bulgaria on September 22.
- BHRP attended the presentation of the 3M final project report on September 24. Unfortunately, none of the key decision-makers from the MOH attend the meeting.

Hospital Reform

- Razgrad region Hospital Assessment was launched on September 10, 2004 by Prof. Dr.Hinkov, Deputy Minister of Health. The meeting was attended by members of Parliament, the Regional governor, representatives from the MoH, local authorities, Regional Healthcare Center, Regional Health Insurance Fund, Regional Physicians Union and the Directors of the healthcare establishments in the region. The health project was represented by the project's COP and the assessment team. USAID's technical officer, Rayna Dimitrova, also attend the launch.

- The BHRP team started the field work on the following week – September 13-17, 2004, beginning with the Regional MHAT and meetings with the local authorities responsible or related to healthcare provision, control, financing, etc. – RHIF, RHC, the Razgrad municipal health department. The week after (September 20-22, 2004) they visited the town of Kubrat and had meetings with the hospital management and staff. The third and last week they visited the town of Isperih and its hospital. Beside inpatient facilities, the team visited and had meetings with representatives of the Regional Emergency Center and its branches, managers of outpatient Medical Centers and Diagnostic Consultative Centers in the three towns and some GPs to receive a broader and as objective as possible perspective of the healthcare provision in the region and related problems.

National Health Accounts

- The COP of the BHRP had a meeting with Dr. Salchev, Deputy Minister of Health to discuss a training of the MoH experts in National Health Accounts. They agreed BHRP to make the training in the last week of September.
- The COP met with Dr. Shterev, Chairman of the Health Commission who agreed on the importance of having a training on National Health Accounts as soon as possible. He stated that the legal amendment should be ready by the end of 2004 and he would work together with Dr. Salchev to have the proposal out soon.
- The training started on September 28 in Bansko. It was attended by experts from the Ministry of Health (3 people), National Center for Health Informatics (3 people) and the National Center for Public Health (3 people). The training was titled: Institutionalization of National Health Accounts in Bulgaria.

ANNEX 1

Agenda
National Health Accounts Workshop
September 28 – October 1, 2004

Day 1 – Tuesday, September 28
Introduction to National Health Accounts

1:00 – 1:30 Welcoming Remarks
1:30 – 2:30 Conceptual Overview of the NHA methodology
2:30 – 3:00 Break
2:45 – 3:15 Regional trends in health expenditure
3:15 – 4:00 NHA objectives and application

Day 2 – Wednesday, September 29
Define Sources, Uses & Flaw of Funds

- Draw the flaw of Funds within the Health Sector
- Define Sources
  - Public – government, social insurance, parastatals, donors, others
  - Private – households, private insurance, NGOs
- Define Financing Agents

Day 3 – Thursday, September 30
Define NHA Classifications

- Define Provider and Functional Classifications
- Identify the Core NHA Matrices Relevant to the Bulgaria's Policy Issues
- Identifying Data needs

Day 4 – Friday, October 1
Populating the Cells and Agree on Next Steps

- Populate the Cells
- Identify Problems and Data Gaps
- Developing a Workplan for NHA Estimates

- At the end of the training the trainees were asked to fill-up evaluation papers. Everybody came out very pleased with the presentations and the exercises and expressed their hope to have the same meetings in the future.
- All participants will receive certificates in the beginning of October on an official ceremony from the Dr. Salchev, Deputy Minister of Health.

BULGARIA HEALTH REFORM PROJECT

Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810

OCTOBER 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

Prepared by:

BearingPoint, Inc.
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USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 15
October, 2004

Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
Contract Number:	PCE-I-00-00-00014-00
Task Order:	810
Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

Hospital reform

- During the first half of October 2004, the assessment team for Razgrad region compiled, reviewed and analyzed data gathered during the three weeks field work in Razgrad and started writing the hospital assessment report.
- Working groups set up by the Ministry of Health in the previous three regions where the project has conducted an assessment had to prepare their own proposals, based on the project's reports and what they consider as reform priorities for their region. Mr. Alain Corvez – a WHO expert, visited the three regions and took part in the working group meetings. The groups presented progress made in developing the regional strategy for health care restructuring according to needs. Mr. Corvez prepared a report for the MOH from his mission - October 19- 23, 2004. See Attachment A.
- At the end of the month, starting October 26, the MOH invited the USAID BHRP to participate in the joint meetings of the regional working groups (RWG) - Gabrovo and Lovech - with representatives of the national working group including Deputy Minister Salchev. The Deputy Minister noted the slow progress made in the regional groups and suggested that the BHP staff should facilitate the following meetings in order to assist the process and that the RWGs should be ready with short but serious initial proposals by November 20, 2004.
- A meeting of Gabrovo RWG as well as a series of separate and joint meetings was held with Regional health center Directors, Directors of regional, specialized and municipal hospitals and the whole working groups. The Project team prepared different scenarios for every region, taking into account the findings and recommendations previously made in the reports, as well as some new ideas reflecting concepts developed in the report for Stara Zagora that were not discussed in the reports for Gabrovo and Lovech.
- The BHRP proposals/scenarios were discussed on separate meetings with every RWG. As a result agreements were achieved in every WG on the main priorities that should be addressed in order to start changing the healthcare provision system to reflect the needs of the serviced population and assure better access to care together with improved quality.

- A second mission of WHO advisers visited the country and spent most of the time working along the BHRP experts with the national WG and RWGs. The three WHO experts reviewed the agreed upon proposals and tried to assist the groups to structure priorities in time.
- Detailed minutes on every working group meeting are available in Bulgarian.

National Health Accounts

- Ibrahim Shehata has been working with the National Statistical Institute (NSI) with their project with EuroStat to complete health accounts estimates for 2003. Shehata has met with Ms. Finka Denkova from NSI to coordinate the work being done by institute with the Ministry of Health efforts to institutionalize health accounts. The Eurostat project does not provide for technical assistance and the NSI have requested that the BHP would provide the needed technical support with defining and classifying health expenditures.

ATTACHMENT A

WHO Mission to Bulgaria
19-23 October 2004

Municipal hospital restructuring
Technical support to regional working groups

WHO mission team:

Dr Alain Corvez, WHO Temporary Adviser

Table of contents

1 Introduction

Scope and purpose of the mission

This mission was preliminary to the mission of the WHO team on hospital reforms, planned on 8-12 November 2004. It built on the basis of reports released in May 2003 and May 2004. Recommendations have been provided to the Ministry of Health on municipal hospital restructuring in four pilot regions, supported by a 2 M US $ loan from the World Bank. Municipal hospital restructuring should lead to decreasing of excessive beds numbers and to a new organisation of hospital services at regional level, differentiating between levels of care to better respond to population's needs.

The three regions for which assessment reports were available (Lovech, Gabrovo and Stara Zagora) have been visited during this mission, and regional working groups were met to discuss their proposals regarding municipal restructuring in their region. A meeting was held with officials from the Ministry of Health as well as an interview with deputy Minister Dr Petko Salchev.

Previous steps

Since October 2002, the Ministry of Health has already undertaken major steps towards restructuring municipal hospitals in four pilot regions. These pilot restructurings are supported by a 2 M US $ loan from the World Bank for investments in restructured facilities as well as extra resources for staff retraining when restructurings imply consequences on human resources.

As to facilitate the process of restructuring hospitals, the government put important efforts on training and education (through cooperation with the Swiss government, benchmark activities, use of statistics data…).

A very large number of meetings were carried out at the Ministry of Health (with the national working group) and in the regions to support local stakeholders in dealing with regional diagnosis and formulating clear propositions on hospital restructuring. Nevertheless, until now little progress has been made and many of the stakeholders still stick to theoretical vision of what should be done.

For more than a year now, the firm *Bearing Point* has been conducting studies in the four regions that chose to take part in the pilot. Only three out of the four reports have been released, namely for the regions of Lovech, Gabrovo and Stara Zagora. The reports are analytical and contribute to focus debates on interpretation of minor details when a more synthetic, strategic report could have helped out focusing on better sharing hospital activities in the regions.

Two previous WHO Missions tried to stimulate the stakeholders and bring clear objectives in conducting this project of hospital restructuring in regard with public health necessities and comparing with similar experiences abroad:

- The first mission in may 2003 put together a framework for restructuring municipal hospitals and tried to provide the Ministry of Health with realistic recommendations in terms of methodology to fulfil the goal.
- The second mission in may 2004 tried to collect the principal difficulties felt by the different stakeholders and put forward some scenarios in term of quality and organisation to get started.

2 Summary of field visits

Meetings with the working groups in Lovech, Gabrovo and Stara Zagora were serious and friendly but let an impression of extreme passivity on regional working groups' side.

An apparent willingness to change things …

- Though these regions are really different in term of perspectives and type of medical situations, there is a general agreement about the necessity of reform, an apparent good willingness to start doing something but in the meantime a common attitude of extreme passivity towards any action.
- All regional working groups had almost the same attitude towards the assessment reports produced by the firm *Bearing Point*, i.e. criticizing the proposals felt as too directive when they deal with their own facility and asking for another report updated and more favourable to their demands.
- The regional working groups didn't seem concerned by the threat of economic shortening and most of them acted as if they could continue getting support from the State even if they don't bring any change within the system.

But real differences in the attitude of the three regions though

Beyond this common attitude, there were really different atmospheres surrounding each of the visits.

Lovech

A good balance of local officials, hospital managers and of physician unions' representatives was found in Lovech. The working group seemed neat and accurate. Not much concern was made about the Bearing Point report as actors fixed to a more systemic discussion. The small size of the region and the number of small hospitals was a good opportunity to talk about the relations between primary care and small hospitals.

Although we have had long discussions about networking activities and subsidiary graduation for the practice, nobody seemed willing to make any clear proposition about reducing beds and sharing activities.

No evocation was ever made of the prison hospital and of the need to rethink its relations with acute hospitals.

Gabrovo

The visit to the Gabrovo region was more political, as the deputy governor of the district tightly supervised the debate. The composition of the group was clearly oriented towards the representation of municipalities and the health professionals attending the meeting were clearly asked to talk about their concerns with the *Bearing Point* report on their own hospital.

Even if I tried to bring the debate to the issue of sharing activities and planning networking organization, there was no possibility to get time enough to bring the subject to a more systemic approach. This of course led to hard criticism of the *Bearing Point* report and to the clear choice of sticking to the current situation.

Stara Zagora

Stara Zagora is an interesting place for hospital restructuring because of the size of the district, of the variety of hospitals met… It clearly indicates that it could be the only place where conclusions could be helpful to roll on the municipal hospital restructuring process on a nationwide level.

Most of the actors were from the health administration or medical staff and directors. Representatives from municipalities were not much involved.

As the debate was at first put on the issue of University and Regional hospital – which is still a matter of conflict - I decided to have a long explanation about outpatient and inpatient activities, but also on the meaning of subsidiary networks leading to shared activities. This should facilitate the closure of hospital beds.

A lack of contact with the national working group

In the absence of Assoc. Prof. Alexandrov, we had only a short reporting meeting at the ministry of health with Dr Chenkova. The only subject was the conclusions of the mission but there was no further discussion about the role and the work undertaken by the national working group. It has not been possible to discuss the position and difficulties of the national working group. It will have to be a major purpose for the next visit.

3 Recommendations

Our recommendations focus on the need to have a strong leadership in this pilot reform and on the need to work closely with the regional working groups for the next steps of this pilot. Efforts will have to be put on the communication strategy towards the region, especially when it relates to the management of human resources when restructuring hospitals.

3.1. A strong political message is needed to move forward

Being candidate to the pilot test on municipal hospital restructuring was not mandatory and gives a specific responsibility to the participating regions. Being part of the pilot on hospital restructuring is certainly a major opportunity. Two years were spent to build the methodology of carrying out the pilot test. It seemed obvious that the Ministry of Health had decided that it was now time for action, and it should be made clear to local stakeholders.

The participants should be aware of the potential consequences of their passive involvement in the project, including the loss of financial resources available today. It should also be made clear that the system as it works today is not sustainable in the long-term and that the government will be obliged to undertake administrative measures to lower the number of exceeding beds anyway.

This strong political message should be brought to members of the national working group but also clearly asserted in each experimental region in front of the major leaders of the working groups.

3.2. The insurance of keeping a close contact with the regional working groups should be renewed

3.2.1. Trying to avoid fear and bringing more confidence into the process

- All participants should have the conviction that the process is long and complex and difficult but that it is no reason not to begin.
- Participants should also be aware that there is nothing to be scared of and should be convinced that the worst danger is to stay where they stand, without moving forward.
- They should also be aware that time is playing against them and the degree of freedom and flexibility they can keep in the process.

3.2.2. But also by strengthening strong methodological approaches

Of course, the reform should be conducted from top to down and from bottom to up in two complementary ways.

There is tremendous responsibility of the national working group

Specially in this second stage of the pilot more dedicated to action, the national working group has the responsibility of putting the necessarily pressure on the local actors while building with them, on an everyday basis, concrete steps for hospital restructuring.

As in most restructuring plans the principal fears (and resistance) are due to jobs losses, it is of great importance that the ministry of health brings a clear view of the whole process, including of the transfer of jobs that should occur and of the strategies for retraining health professionals to

get more adapted to other tasks they could carry out in social and medico-social care.

As well as for the structures themselves, cooperation and sharing activities must be based on clear contracts and well-defined incentive measures. Communication and transparency on these issues are essential.

An adverse effect of the use of Clinical Care Pathways is that they provide a strong incentive for all hospitals to produce more acute care (better reimbursed), sometimes disconnected from the real needs of the patients on a territorial level. Before the formal introduction of Diagnosis Related Groups, the use of new incentives to counterbalance this adverse incentive should be thought over by the national working group.

Accompanying the process with the regional working groups must be of a daily concern

There is no time left now to discuss for hours on the Bearing Point report. The reports don't bring operational solutions but still contain plenty of useful informations about the structures, which can lead to a more territorial medical project. Therefore three major questions have to be dealt with: What are the necessarily implications of a territorial approach? What should not do hospitalisation? What is the benefit of a three level graduation for the supply of hospital services?

What are the necessarily implications of a territorial approach?

The following issues will have to be dealt with by the different working groups:

- Can we agree on a medical and epidemiological diagnosis on our geographical area?
- Do we agree with the inventory of the offer and if not can we quickly bring correct data to the discussions.
- Can we agree on the number of beds to cut?
- Now we have had time to react on this, are we ready to build realistic solutions to improve the situation?
- Are we ready (with the help of working groups) to build a medical project in term of scenarios and with a clear and quick agenda?

What should not be hospitalisation?

In most country, due to rising costs the problem of appropriate hospitalisation is getting more and more accurate as the flow of hospital patients is constantly increasing. This leads to a particular attention on four types of organisation, that are to be discussed on each territory even prior to any discussion on the needed number of hospital beds.

- How is performed primary care and particularly how is organized emergency and home care (24h/24h) on the remote territories of the district but also in major cities?

- What is the number of patients in hospital only due to social purposes?
- What is the capacity to cope with post-cure structures and care to avoid long stay in acute hospitals at regional level?
- Are there elements of performance that could lead to shorter length of stay of patients for whom hospitalisation was clearly needed?

These are fundamentals questions that should be dealt with first by the local working group, not with the first aim of reducing all hospital excesses in one time but with the clear conviction that there are margins of progress outside the hospital own activity.

What is the benefit of a three level graduation for the supply of hospital services?

All patients do not need to go to the same level of care and there should be a graduation in the supply of hospital services.

- This principle can give a lot of flexibility to the organization of hospital services and brings an interesting approach as it shows that number of beds is less and less an appropriate figure compared to how activities are carried out.
- Performing graduation is a difficult exercise requiring confidence and relying on three major necessities that should be discussed from the beginning:
  Quality and security: there should not be less quality at the lowest level and the best chance should be given at the appropriate level conferred by the patient's disease.
  Subsidiarity: what should be done at a lower level has not to be done at an upper level.
  Objectivity: every medical situation can be discussed on reliable data from a good information system

- A three levels graduation of hospital services gives a meaningful stake to hospital restructuring.

- Starting on a territorial approach and putting the reflection on patient's needs gives a clear opportunity to bring graduation of the supply of hospital services as a major tool to move the reflection on hospital restructuring from bed-centred to activity-centred (thus bringing in new winner-winner alternatives).

The **first level,** also called local level or proximity level must be built with an extreme attention.

This level is strongly linked with the primary care level performed in town and so depends for a good part on the quality of the primary care system.

Though, it can define its own content, which in case of ageing population can be a real opportunity. The responsibility on this subject is to define how many of these dedicated structures are needed, where, with what amount of beds but especially with what kind of care and what guarantees in terms of quality. The national working group should fix precisely

the types of structures especially for elderly people and link up financing to quality standards.

The **second level** is commonly the level where technical equipments and specialists are allocated. That is why it is the level where we can see the most vigorous competition and where we need most cooperation to achieve beds cut-off. At this level, which can build the "intermediate reticulum" of our territories (i.e. hospitals in most mid-size range cities), the planning action should be performed on a two-way basis:

- Sharing activities means that nobody can do everything and that most redundant activities as are described in the Bearing Point report are not acceptable in a country where trying to do better for more people with small budgets is a major concern. This means that actors have to find agreements on sharing activities and if not, the Ministry of Health should take over this responsibility.

- Developing network activities is also a way of decreasing beds and cost leading actors to build real and sustainable partnerships. It has to be encouraged by the national working group. Financial incentives should be developed.

The **third level** was of major concern for the local working group in Stara Zagora but in fact concerns the limited population needing university level care:

- Innovation and research activities should be encouraged and based on clear contracts with the State (including proper financing)
- Education and training of health professionals and health managers should be of major concern in order to guarantee a good quality of care in all parts of the country, including remote areas.

4 Next steps

Confirm the strong political willingness

Standing by is not rational. Work has been carried out during the last two years, resources are available and the pilot tests can bring exemplary changes to the system. These changes are needed.

Rapidly invest financial resources on some remarkable actions to get started soon

It would be useful to put resources on benchmarking projects, which could be carried out at the three levels in a complementary fashion:

- Level one: remarkable restructuring of local hospital(s) for elderly people.
- Level two: cooperation contracts and finance to start with
- Level three: exemplary project on regional training program(s)

Still accompany the actors with sharing experience programs of education

There is still a strong need of practical education to achieve a smooth transition between concepts and theory and real situation. Investing on change management is still dramatically needed.

BULGARIA HEALTH REFORM PROJECT

Contract № PCE – I – 00 – 00 – 00014 – 00
Task Order 810

NOVEMBER & DECEMBER 2004 MONTHLY REPORT

Prepared for:
USAID Bulgaria

Prepared by:

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USAID HEALTH PROJECT SUMMARY AND REPORT
Monthly Report No. 16
November/December, 2004

Project Title:	Bulgaria Health Reform Project (BHR)
Contractor:	BearingPoint, Inc.
Contract Number:	PCE-I-00-00-00014-00
Task Order:	810
Period of Performance:	April 30, 2003 – April 29, 2005
Project Manager:	Ibrahim Shehata

Progress, Accomplishments, Issues and Events

General

- The DRG National Training Program that started in June was completed by the end of November with Training Courses – 1) training coder form all hospitals in coding of and 2) training in coding of the head nurses form all hospitals.
- Mrs. Jugna Shah arrived for ten days in November (November 3 through November 13). Her SOW for this trip was to provide technical assistance to the NHIF case-mix office to get them familiar with the AR DGR grouper software, that USAID/BearingPoint purchased for them for the period of one year and also to run the data (clinical and economic) from the pilot project hospitals, that they collected so far. During her stay Ms. Shah met also with senior officials and one expert from the opposition socialist party.
- A round table on Institutionalizing National Health Accounts in Bulgaria with expert from the MoH on which were handled certificates for successfully completed training course.
- BHRP participated in several working groups in the three assessed regions.
- Ken Cahill made a short trip to Bulgaria in early December (7-10), on his way to Jordan, to discuss BHRP activities and progress and meet with USAID CTO.
- The World Bank had a five-day mission headed by Mr. Enis Baris to meet with health decision makers and discuss health reform activities. BHRP COP met with Mr. Baris to discuss and coordinate the hospital financing and restructuring activities. Shehata explained to him the government's decision not to move forward with pilot implementation of the DRG financing fearing any changes prior to the national elections. Also debriefed him on the meetings with the local working groups to discuss restructuring recommendations.

Inpatient Care Financing

- The last training session for nurses and coders from all Bulgarian hospitals was offered in November. The National Training Program (NTP) for hospital financing using DRGs as the method of financing has started in June 2004 and

continued without interruption through end of November. More than 1600 nurses, coders, accountants have participated.

- Mrs. Jugna Shah arrived for one and a half week on November 3rd. She and Ibrahim Shehata met with Deputy Minister Salchev who updated her on the current political environment. He stated that the pilot financing for using DRGs as a main method of hospital financing in 2005 is likely to be postponed for 2006 to sudden indecision on behalf of the political decision makers in anticipation of the national elections in June 2005. This may mean that implementation may go straight to national implementation level without having any pilots, which is not something that the project recommends in anticipation of the many likely problems that will surface and will require ironing out prior to any national implementation.
- The deputy minister, however, assured us that regardless of pilot implementation in 2005 that procedure and diagnosis data collection should not stop and that it will be extended beyond the pilot hospitals to all Bulgarian hospitals after receiving the hardware and software set ups in 2005. That requires an order from the Minister of health. 2005 will serve to the case mix experts as an opportunity to improve the data quality and to play different scenarios for financing.
- The Task Coordinator of the BHRP and Mrs. Shah created a new timeline for the period covering the end of 2004 through 2006. (see attachment 1)
- BHRP and Mrs. Shah had contacted to the Australian government and authorized software companies to receive a research right of the AR DRG grouper software. Thanks to the project efforts the NHIF had signed a Deed of Confidentiality with the Australian Government, base on that can receive the rights to use the software. The Bulgarian decision makers have not made a final selection for what to be the software products. They want to see an evaluation with at least 2 internationally used groupers and play with real Bulgarian figures. Some grouped data (with their IR DRG Grouper) will be distributed through the WB/3M pilot project and will be assessed by the case mix experts. Bulgarian Health Reform Project/USAID bought a research licence for the Australian grouper (AR DRG) the period of one year. During that time the case mix office can run all collected data, prepare budget simulations, compare the results to the 3M IR DRG, and others. The AR DRG was given to the NHIF in the middle of November.
- Mrs. Shah worked together with the Gamma Counsult (the company that has developed the software for the pilot hospitals) expert to create the input and the output files. She explained some of the most important steps in using the AR DRG grouper to the case mix staff.
- During her stay in Bulgaria she met along with Ibrahim Shehata with Dr. Emil Raynov, a health expert form the socialist party. The purpose of that meeting was to update him on the work that has been accomplished by the project thus far and to ensure the continuity of the health reform in case the BSP won the June 2005 national elections. He emphasized that the current government lost the momentum to change the whole system. Now, they do not have a long-term strategy in 2005-2006-2007. No change will be made by the end of this government mandate. The new government has to think of major changes like having only one source of financing and increasing the percentage for healthcare as a total of the GDP; get

the patients on the table to negotiate the National Framework Contract being the most interested party. BHRP and Mrs. Shah agreed with all that and offered their assistance to the socialist party, seen as the next ruling party.

- BHRP attended the presentation of the final results of the WB/3M pilot project. The MOH Deputy minister and the directors of the pilot hospitals attended it as well.

Hospital Restructuring

- At the end of October 2004, the Ministry of health requested the assistance of USAID-BHP in coordination of Regional working group /RWG/ meetings and facilitation of the whole process of generating ideas, group discussions and drafting a new health care plan for each region.
- The deadline for preparation of RWG proposals was November 20, 2004. The Ministry of health should present the scenarios to the World Bank mission in the beginning of December.
- The Project team prepared different scenarios for every region, taking into account the findings and recommendations previously made in the reports, as well as some new ideas reflecting concepts developed in the report for Stara Zagora that were not discussed in the reports for Gabrovo and Lovech.
- Starting November 2, with the meeting of Gabrovo RWG, a series of separate and joint meetings were held with Regional health center Directors, Directors of regional, specialized and municipal hospitals and the working groups.
- The proposals/scenarios elaborated by BHP were discussed on separate meetings with every RWG from November 2 to November 10, 2004. As a result agreements were achieved in every WG on the main priorities that should be addressed in order to start changing the healthcare provision system. The main objective of this change should be to respond to the needs of the serviced population and assure better access to care together with improved quality.
- During the week of November 8-12th, 2004 there was another mission of the three WHO advisers visited the country. They spent most of the time working with the national WG. On 11th and 12th November the WHO experts participated in the RWG meetings in Lovech, Gabrovo and Stara Zagora. They reviewed the agreed upon proposals and assisted the groups to structure their priorities in time.
- In the second half of November the team continued the work on Razgrad report and finished the initial draft.

Attachment 1

2005 Required Activities to Implement the DRG Base Financing System in Bulgaria by 2006

Critical Path for 2005

- Continue collecting clinical and economic data from the 43+ pilot hospitals & expand to all Bulgarian hospitals through a Ministerial Order
- All Bulgarian hospitals to receive hardware and software through the World Bank
- The NHIF Case-mix to group clinical data using the AR-DRG grouper and any other groupers received for evaluation, calculate relative weights, simulate budgets, and develop feedback/management reports for hospital managers on a regular basis
- Classification system and grouper software selection for long-term use and adaptation
- Continue refining the process to develop relative weights/cost for use in modeling budget simulations
- Decision makers to determine whether DRGs will be used as the basis for hospital financing mechanism starting on January 1, 2006
- Legal amendments should be drafted as necessary to introduce the new hospital financing system based on DRGs

November-December 2004	2005 – YEAR OF DATA COLLECTION, CODING, COSTING AND EVALUATION	2006
→ National Training Program to end by Dec. → Case-Mix office to analyze 3M/WB data → Case-Mix office to group clinical data using the AR DRG grouper and any other groupers received for evaluation → The WB tender procedures for Software and hardware to be left out → Decision makers to commit to clinical data collection from all hospitals in 2005 and beyond by issuing a Ministerial Order	→ 43+ pilot hospitals to continue reporting data to the NHIF Case-Mix office → All other hospitals to begin reporting data after hardware and software installation → NHIF case-mix office to collect, process, and group the data received → Monitor and support hospitals process of collecting clinical & economic information → Case Mix office to provide management reports on volume and type of cases by DRG to the 43+ pilot hospitals regularly and to expand this to all other hospitals if possible → Training in coding, data collection, and DRGs to continue as necessary → Create and distribute DRG related reports to decision-makers → Case-Mix office to prepare a comparison paper of various relative weight sets, including the options for selecting relative weights & creating Bulgarian relative weights → Case-Mix office should prepare budget simulations based on DRGs → Decision makers to select a grouper software and relative weights that will be used to finance a selected number of hospitals starting in 2006 → Technical staff and Decision Makers to prepare all the necessary steps in the context of broader health reform for the new financing system based on DRGs that will be used → Prepare legislative papers and legal amendments related to hospital financing (hospital	→ NEW financing system implementation to begin! → Continue data collection → Continue refining the regulations and legislation (i.e. related to data security, transmission, processing and laws related to giving hospital managers autonomy) → Decision makers to define the rules and responsibilities of the key institutions in the new financing scheme Prepare and develop Bulgarian classification system and update the relative weights/cost